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CHALLENGES FOR WOMEN: TAKING CHARGE, TAKING CARE

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UNITED STATES SENATE

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CHALLENGES FOR WOMEN: TAKING CHARGE, TAKING CARE

MONDAY, NOVEMBER 18, 1985

U.S. Senate,
Special Committee on Aging,
Cincinnati, OH.

The committee met at 9:30 a.m., in the City Council chambers, City Hall, 800 Central Avenue, Cincinnati, OH, Hon. John H. Glenn, Jr., presiding.

Present: Senator Glenn and Congressman Thomas A. Luken.

Also present: Diane Lifsey, minority staff director; Eileen Bradner, professional staff; and William Benson, professional staff.

OPENING STATEMENT BY SENATOR JOHN GLENN, PRESIDING

Senator Glenn. The hearing will be in order. Good morning. First of all, I want to welcome each and everyone of you to this hearing of the U.S. Senate Special Committee on Aging.

This is an official hearing of the committee. We have these field hearings, as we call them, from time to time, to supplement the hearings that we have in Washington, DC, where people come in from across the country and give testimony on the many issues affecting our Nation's elderly.

This particular hearing is entitled "Challenges For Women: Taking Charge, Taking Care." It is a very special pleasure to be holding today's hearing in Cincinnati. I especially want to thank Mayor Charlie Luken, the City Council, and the city of Cincinnati for making these facilities available to us; and we are particularly happy that Congressman Tom Luken can join us for a part of the hearing.

Today's hearing is the third in a series I am holding on the topic of "Women In Our Aging Society."

The purpose is to examine the challenges raised by the aging of our population and particularly the changing roles of women, so that we can begin planning our policies and programs to meet the needs of the future.

Let me add right here that I think we in Washington tend to be crisis oriented. We too often act only when a problem is pressing us, and we are going to have to do something and do it right away. For once, at these hearings, we are trying to look at what is occurring in our society, so that we can plan for the future.

We are looking at the changing demography of our population—the aging of our population—and what this is going to mean economically, particularly with regard to women. While these changes affect all of us, the impact is especially profound on women because, frankly, women outlive men. It is that simple.

As an indication of how women's roles have changed, just let me share with you what happened on this day 113 years ago, on November 18, 1872. This could be classed as a trivia question, I guess, but it deals with a subject that is not trivial—because on November 18, 1872, Susan B. Anthony and 12 suffragettes were arrested for attempting to vote!

Now, a 100 years later, American women make up the majority of the registered voters in this country, and as a group are demonstrating increasing political clout. Today there are three times as many women serving in State legislatures as did 15 years ago and 25 women serve in the U.S. Congress. I am hopeful that the number of elected women will continue to grow.

I am proud that Judge Lillian Kern is participating in our panel today; and two of my distinguished colleagues, Representative Mary Rose Oakar and Representative Marcy Kaptur, helped chair our two previous hearings in Ohio.

Public service is just one area of our society where women have made a very significant impact. We all know that women's participation in our economy is growing and is changing. Women now account for 53 percent of the American work force—53 percent—as compared to just 32 percent in 1960.

Now, that doesn't mean that those who stay home and take care of the family are not working. I can guarantee you that. I see homemaking as a profession also, but what we are talking about are jobs outside the home. The younger women now entering the work force are better educated and many of them are establishing themselves in careers that traditionally have been dominated by men.

The changing roles of women in our aging society have wide ranging implications—for Government programs, for health care, and social services, and for the subject of today's hearing—family and community life.

So, today, it is especially important to look at the changing American family and its impact on women. American family life is no longer like it used to be for Ozzie and Harriett on TV. Some of you are old enough, as I am, to remember that program. Many of the changes from those days have been good—like the expanded economic opportunities for women and the increases in life expectancy. But you know there are some other changes that are not so good.

My own family—my wife Annie is in the audience, there she is back there—is not an exception. We live in Washington. Annie's mother, who will be 90 in December, lives in our place in Columbus. Our daughter lives in Colorado and our son lives in San Francisco. So, by and large, across the country, we are no longer families that grow up and remain in one community. There are other changes that are also disturbing—high divorce rates, broken homes, women as single heads-of-households, the separation of families through increased mobility, and the health and economic difficulties faced by many older people.

What do these changes mean for society, particularly for women?

What are the rights of grandparents who wish to maintain contact with their grandchildren whose parents are divorced?

In addition, with smaller families and the likelihood of our living to older age, are our housing needs adequate? Do we need to try to keep people in the same community and provide them the services they need, such as Meals on Wheels Programs or medical care?

How is the business community responding to demographic trends and the changing roles of women? Are they changing their marketing and advertising strategies?

These are some of the topics that our panel on the "Family of the Future: Society in Transition" will deal with.

One of the most significant trends that we must consider is the fact that we are living longer. Life expectancy is 71 years for American men and 78 years for American women. Women outlive men by an average of 7 years, but that's not all, because the fastest growing segment of our population is the age 85 and older group—and 70 percent of those people are women.

I guess we could say that in the future the baby boom is going to turn into the senior boom.

When the real senior boom occurs about 25 years from now, we are going to see a fourfold increase in the number of people over age 85, and a doubling of the number of older women. That's why we want to look at some of these trends now.

For those of us fortunate enough to reach 85 years and beyond, we face an increased likelihood of becoming severely disabled or physically limited. This old-old population often needs the assistance of caregivers. The majority of caregivers in our society have been women.

So the need for caregivers will grow dramatically due to demographic trends. We don't want to just say, "We are going to live longer, but have a lousy life if we do." We want to live longer, but we also want to live well.

I am disturbed by the myth that persists in our society that families are somehow abandoning their elderly members and unloading them to nursing homes and public programs. This may be true for some and we have had some horror stories from testimony in Washington. But, basically, that myth could not be farther from the truth because families provide the bulk of personal care for the elderly in our communities.

This responsibility often falls on the shoulders of wives and daughters. In fact, women make up about 70 to 80 percent of the caregivers. More than 1 in 3 impaired men are cared for by their wives, but only 1 in 10 impaired women are cared for by their husbands. That's certainly not because husbands don't care. They are just not there to give that kind of care.

This reflects the fact that women tend to marry men older than themselves and women live an average of 7 years longer. Spouses and daughters are most often the person to serve in the caregiving role.

It is of particular significance that many of the caregivers are themselves aging. According to a recent report by the population Reference Bureau, the average age of persons caring for an impaired spouse is 66, and the majority of offspring caring for an impaired parent are over 50. Elderly wives providing care for impaired husbands are likely to face a decade of widowhood with few or no children capable to care for them.

Too often, we in Government, as I said, wait for the wreck to occur before we try to fix the problem. With this hearing we are trying to look ahead and do some things now. These facts raise important issues that we must address to prepare for the future.

How will women cope with the competing demands of caring for dependent family members and maintaining a full-time job outside the home? Who will care for the caregivers as they themselves become older and impaired? How can the Government and the community support women caregivers, both formally and informally, to make their tasks more manageable? These questions will be discussed by family members and professionals on our second panel, "Caring and Coping."

To help us begin our discussion today, we have Dr. Robert Binstock of Case Western Reserve University in Cleveland, who will give us an overview of the challenges that face our aging society. He will point out that we cannot hope to meet these challenges by simply throwing money at them. Instead, we must rethink our policy in such areas as long-term care, family structure, and labor force participation.

The main purpose of this series of hearings is to look ahead and plan for the needs of our changing population, instead of waiting until the midnight hour.

I want to take this opportunity to express my personal deep sadness. Anna Brown, of Cleveland, passed away last week. Anna worked tirelessly to improve the lives of older citizens as the director of The Cleveland Department of Aging and as president of the National Council on the Aging.

I was continually impressed with her success in linking families, community groups, and the public and private sector in her programs to benefit senior citizens. She traveled all over this country to share her fresh ideas and innovative programs with others in the aging network.

We were fortunate to have Anna testify at our first hearing in Columbus last year on "Women in Our Aging Society." I can tell you she brought the house down with some of the her suggestions for change. She was a dynamo. I have made her statement from that hearing available in the lobby for all of you to read.

We have a number of pamphlets and papers out there dealing with different parts of this whole issue as well as Anna Brown's statement, that you may want to pick up and read later on.

As the senior Democratic member of the Senate Special Committee on Aging, I often relied on Anna's expertise, and I valued her friendship. She will certainly be missed by all of us, but her outstanding contributions to aging and the problems of aging will live on in many of our communities.

In closing, let me share what Dr. Robert Butler, former head of the National Institute of Aging in Washington, and now head of the Geriatrics Department at the Mount Sinai Medical Center in New York, said at our first hearing. He said that "Just as many people are coming to perceive that individual aging is a mixture of pluses and minuses, ups and downs, so they must also see that population aging is a frontier."

Many opportunities lie beyond for us in dealing with this frontier and life beyond. So thank you all for joining us here today to explore this frontier and the challenges that lie ahead. We welcome Congressman Tom Luken here today. This is his home district, of course. We welcome any comments you have, Congressman Luken.

STATEMENT BY CONGRESSMAN THOMAS A. LUKEN

Congressman LUKEN. Thank you, Senator. I would like to officially welcome you and Annie back to Cincinnati. It hasn't been a long time since you have been here before and I think we should all take note of that.

Senator Glenn takes a deep and abiding interest in Hamilton County. It was 1 or 2 months ago that he was here with Senator Cochran of Mississippi on the problems of Fernald, the environmental issues, the safety of our entire community which has really consumed much of the people in this area.

So Senator Glenn is very much of an active force here in Hamilton County, and I think we should recognize him.

Today as the summit begins and the problems of the total universe are considered, I think we also should congratulate Senator Glenn and his committee for considering not just the total universe, but the universe of the family, the family in transition of society, transition of the family in society.

The family often ends up a unit of poverty especially when it is a single person family, a single parent and the head of the household, and that person is often a woman.

So the problems then become obvious. They are problems of health and housing, of job training. The average life expectancy of women at 78 years and the over 80 age group, the largest expanding group in our society, women are not only the caregivers, but often the carereceivers.

So we have to look at the harsh realities of today. The long-time dream that biomedical science will achieve a breakthrough, now looms as a nightmare because it may exacerbate all of these situations. Caregiving has been accentuated in developments on Medicare, for example. Hospitals discharge people, the elderly, too very quickly, expediently for them, but not expediently sometimes for the patient or the victim, as it turns out.

The family emphasis is very important. Medical improvements have led to four-generation and even five-generation families. Women, as we have said, who were formerly caregivers are now in the workplace and either not available or available only part time for caregiving. This creates family stress.

Expectations that the family will provide a greater volume of informal supportive care are totally unrealistic today. We are in transition. We are looking for, therefore, and we need alternatives, alternatives to the dilemma of institutionalization or simply home care.

Compulsory insurance for long-term care is just one of the alternatives, one of the possibilities that have been suggested today. Medical developments complicate the situation, including the prohibitive cost of insurance, deductibility and coinsurance on Medicare, and as the Federal budget crunch becomes more and more pressing, hearings like this are so important because the Federal budget, as it comes from the administration these days, serves only one master.

When we get the pledges from the administration, the only consideration is the budget. From the administration there are only automatic cuts, whether it is in Medicare, whether it is in housing, whether it is in alternative programs or whatever it is, without any care or feeling or interest of any kind in the human problems of those who are affected.

As Senator Glenn so eloquently stated, the purpose of these hearings is to adopt policies which fit the needs of our society, which fit the needs of our people. We can supply these national policies and help to ease their transition to new environment. Thank you.

Senator **Glenn**. Thank you, Tom, very much. I have just a couple of housekeeping details before we get on with the testimony. First, we have some yellow sheets out in the lobby. Those yellow sheets are for everyone in the audience. As you listen to our witnesses today, I encourage you to use those sheets and share your views with us about today's hearing.

At our last hearing held up in Toledo, we received over 300 written comments from the audience. They were valuable contributions to the hearing record and included many good suggestions for further committee work.

We appreciate your comments. We can't have everyone testify as a witness, but if you have some pertinent comment or idea to put forward to us, we would appreciate it very much. Even if you do not have specific comments, we would appreciate having your name and address so we can include you on the mailing list of the U.S. Senate Special Committee on Aging. This way, we can give you information about new publications that we send out occasionally dealing with matters concerning the elderly. So, we ask you to please avail yourself of that opportunity please.

On the tables outside this room we have a number of free publications from the committee and senior citizens organizations. These are available right outside the door. You may have seen some of them when you were coming in. They provide information on a variety of issues, some of which we will talk about today. These issues include housing, long-term care, support groups, and women's needs. We don't particularly want to lug them back to Washington. If you want to take those and make use of them, that would be fine.

I didn't formally introduce Annie. I referred to her a moment ago. Annie, would you stand up? My wife Annie. [Applause.]

I might add that when I ran for President, it wasn't my fault that I did not make it. I want you all to know that because Annie and I started going together at a very young age, I became accustomed to doing everything that Annie wanted me to do—exactly as she wanted me to do it. Annie said repeatedly she wanted me to run for the presidency in the worst way possible. That's exactly what I did.

I also want to take this opportunity to recognize Dr. Mildred Seltzer of Miami University who is with us today, with some of her gerontology students. Would you please stand? She testified at our first hearing in Columbus. Dr. Seltzer helped outline the negative myths and stereotypes of older women which we must work to eliminate.

Now, Dr. Binstock is here to lead off our hearing today. He is from Case Western Reserve. He is the Henry R. Luce professor of Aging, Health, and Society at Case Western. He is very active in the national aging network. Dr. Binstock is a former president of the Gerontological Society of America, which shows what his peers think of him. He currently serves on the National Academy of Sciences Committee on "An Aging Society."

Dr. Binstock has very kindly come down this morning from Cleveland to give us an overview of the challenges facing us in an aging society, and of the need to meet these challenges by rethinking many areas such as family structure, the labor force and housing and insurance needs.

A year ago I asked Dr. Binstock to testify at our first hearing on "Women In Our Aging Society," but he was still teaching at Brandeis University in Massachusetts, and couldn't come to our hearing at that time.

Doctor, we are very, very pleased that we have you here in the Buckeye State. We appreciate you being here and look forward to your testimony. Following your testimony and any questions we may have, I would ask you to join me up here so we can go ahead with the rest of the witnesses. Thank you very much.

STATEMENT OF ROBERT H. BINSTOCK, PH.D., HENRY R. LUCE PROFESSOR OF AGING, HEALTH, AND SOCIETY, DEPARTMENT OF MEDICINE, CASE WESTERN RESERVE UNIVERSITY, CLEVELAND, OH

Dr. Binstock. Thank you, Senator Glenn, and good morning to you and to Congressman Luken as well. I would just like to say at the outset, Senator, I share your sentiments regarding Anna Brown that you expressed so ably.

I am especially pleased to be invited here today since I am not a woman. I think that's a nice tribute. Although we often talk about "the woman in the middle," I often think of myself as the man in the middle. I have an 83 year old mother and 4-year-old daughter. But I expect my wife, however, will end up bearing the burden for both of them as well as for me.

The two of you have expressed so well and so succinctly a number of the things that I was going to say. So I will be very brief.

As you well know, since the outset of this decade, we have had the spectre of an aging society emerge rather abruptly. We have been bombarded by the news media regarding the increasing numbers and proportions of older persons, and I think most of us are now becoming aware of the fact that we spend about 28 percent of our Federal budget on the benefits to the aging.

As we absorb all the issues that have surfaced since the outset of this decade, the prospects of an aging society seem foreboding. Among the many anxieties that have been generated are the economic burdens of sustaining a so-called dependent aging population; moral dilemmas posed by the rationing of acute health care on the basis of old age as a criterion; formidable challenges of financing and developing an adequate and effective range of supportive services; competition in the workplace between older and younger workers in the context of seniority practices, technological change, and age discrimination laws; and much talk about a politics of conflict between age groups.

As you noted, Congressman Luken, the long-time dream that biomedical discoveries might extend the lifespan now looms as a nightmare because of the perceived exacerbation of these anxieties.

Fortunately, most of these anxieties about an aging society are based upon extrapolation from our existing public policies, our arrangements in the private sector, and our social and familial institutions as if they were all on automatic pilot and we were simply going to plug in larger numbers and proportions of older persons. But extrapolation is one of the poorest modes of prediction in a society, because societies are dynamic, not static. The fact is that public and private policies affecting older persons are being modified continuously in important ways and even the recurrence of minor incremental changes has major cumulative impacts.

You mentioned before the series of changes in copayments and deductibles in the last few years. These have had major implications for the cost projections for the Medicare trust funds. They have also had major implications in terms of hospitals verticalizing their industries into long-term care as a way of responsibly and quickly discharging their patients under the pressures of DRG's and other prospective payment systems. In other words, hospitals have been acquiring nursing homes, expanding their rehab facilities, developing their own home care agencies—competing with the traditional market so that they can get reimbursement from Medicare beyond the DRG's.

Similarly, you both noted that social institutions have been undergoing tremendous changes. You pointed to the changing structure of the family, the sustained high rates of divorce, of single people, people who don't marry and live together for long time, and remarriages. We are getting to the point that we don't know whose mother-in-law is whose when we face the issue of taking care of people.

It has been a feeling for a long time in the gerontological field that the more children you have, the better the odds are that you will be taken care of when you are old if it is needed. I am beginning to doubt this. Actually, I think the breaking point is probably about somewhere in the 2 to 2.5 children area because of some of the geographic and other issues we have talked about. I think you get to be a hot potato when there are three, four and five children potentially available for care. The tail doesn't get pinned on the donkey so easily under those circumstances.

So we have to re-examine that assumption as well as the implications of the now, more and more commonplace, four and five generation family. But I think more important to note for the purpose of this hearing today is what you have both noted regarding the changing role of middle-aged women.

We know perfectly well that for many years now 80 to 90 percent of the supportive services provided for older persons outside institutions have been provided by their family members and in most cases that's meant daughters and daughters-in-law or as Elaine

Brody of the Philadelphia Geriatric Center has termed them women in the middle. Now, the changing patterns of labor force participation may make this impossible to continue. I will only give one example. Take women in the age range of 45 to 54. In 1940, 11 percent of women in that age range were in the labor force; today, well over 60 percent are in the labor force.

As you both have implied, as much care as you want to provide, you can't provide all of those elements of care personally if you are out on the job; you can't be at home at the same time. Or if you stay at home, we have to consider labor market economic effects. You don't get the multiplier effects economically if you are at home and withdraw from the labor force; so subsidization by family members doesn't necessarily make sense. I am not urging one way or another. It is a dilemma that we have to look at.

In short, I am suggesting that the last few years should have taught us, if anything, that an aging society will be a very different kind of society than a projection of present arrangements driven by mechanisms of demographic change. We have life care communities and shared housing arrangements springing up all over the place. Southwestern Bell and Bob Hope are marketing a Silver Pages Telephone Book for older persons. There are many forms of long-term care insurance now being explored and tested. We have federally subsidized housing projects for independent living where older persons entered well and now are becoming chronically disabled, as they age in place, and the whole setup is dated. The people who have kindly stepped forward as nonprofit organizations to sponsor independent housing for older persons are now finding that they are not set up, when the older person becomes dependent, to wrestle with the issues of long-term care. Perhaps we can get into some of those issues later.

As we know the world of retirement income is now populated by Social Security, pension integration mechanisms, taxes, the very threatened Pension Benefit Guaranty Corporation, and IRA's. We could go on and on in the health arena as well, but I won't go through all that. All I will say is that I think at this point any person trying to cope with HMO's, Medigap Insurance, Preferred Provider Organizations, IPA's, part B and part A, of Medicare, "accepting assignment," and all this jargon that one must deal with in the health area are probably the way an immigrant felt when he got off Ellis Island into New York City and couldn't speak English. How do you cope with this rapidly changing complex aging society that we are in?

My main point is that the emergence of an aging society appears to be very rapid, not at all easy to predict by looking at the present, let alone the past. I think we need some fresh outlooks to take risky leaps of imagination, to generate some fresh perspectives to cope with an aging society.

Let me take the few minutes that I have left just to illustrate some perspectives on the formidable challenges of financing and developing an adequate and effective range of supportive services for long-term care and rehabilitation of older persons. I won't get into the "and rehabilitation" at length, but I took a vow to myself some 10 months ago that I would never again talk about long-term care in isolation from rehabilitation, as if we were talking about a caretaking of eroding human entities without even making some effort to maintain existing functioning, which is a very important part of rehab.

As you both pointed out, many have looked to the family as a solution to long-term care basically on an in-kind service basis. They're saying: "Let's flog more out of the family, if we can." As you both made clear, the family is not going to be a panacea. First of all, many older persons have no family. Second, some families may be able and willing to finance care for their parents, but others aren't. State laws requiring filial financial responsibility for parents' long-term care are proving to be unenforceable. This is not surprising. We can't even enforce alimony payments in divorces. When you get to the point where you don't know whose mother-in-law's is whose, it is kind of tough to enforce filial responsibility.

Family abandonment of older persons is a myth. Families are probably already stretched to the limits, not only economically, but socially, and sometimes physically, in terms of parent care. But if we could focus on the family, I think we can cut into the problem with maybe a little bit of a fresh perspective.

Elaine Brody has pointed out cogently that parent care is already an expected though usually unexpected family stress. In effect, I think we are going to find parent care support groups striking up around the country very shortly just the way the Alzheimer chapters have developed, but on a much broader scale. People all around them are finding that their age peers in their 50's and 60's are, or have just been, involved in an issue of this kind.

How pervasive will parent care be in an aging society? Nobody can answer this completely, but I think if we look at the issues through the lens of the adult children, maybe we can get a different picture.

You both implied the kind of intractable dilemmas that we have today. Many adult children in their 40's, 50's and 60's are faced with the choices of putting a parent in a guilt-reducing $30,000 a year or more institution, or a guilt-exacerbating Medicaid warehouse (the space age version of the Elizabethan poor house), or taking care of a parent at home, perhaps while putting a child through college, and often undergoing enormous physical, psychological, and social stresses.

In fact, I often wonder if those who urge that more families should take care of their elders and who are strong advocates against elder abuse, have ever stopped to ask how many instances of elder abuse may come up because somebody can't stand caretaking any more or needs some rest from it. Maybe we can explore that later on as an issue.

In any event, faced with these intractable situations, many adult children may become a source of new demands. If we focus on this element for a moment, we can stretch ourselves.

Clearly one arena in which we can see a demand expressed for long-term care elements is in the private market. That is to say, those in the middle income brackets and middle years and involved with parent care can purchase more and more elements of the nonmedical but very important elements of care that are necessary for maintaining someone in the community.

But I think a much broader concept is one that can take place in the workplace, through collective bargaining if unions ever get any power back, but perhaps designed by insurance companies and firms as they begin to see the sense of it. The concept would be to provide insurance for the working aged, middle aged, 40's, 50's, and 60's persons, against long-term care for their parents. One of the big problems in developing comprehensive and extensive long-term care insurance has been what the insurance industry calls "adverse selection." You don't go out and sell long-term care insurance directly to people in their 70's and 80's who are most likely the people to be the claimants for benefits. So how do you spread the risk? Well, we spread maternity benefits, not by selling policies to infants or to fetuses, obviously. We spread the risk through an indissoluble package in the workplace. You can't say, "I am not going to have any children; I don't want to pay that part of the premium." By the same token, workers would not be able to say "I don't have any living parents; I don't want to take this long-term parent care insurance."

I think that's the concept we are going to see within 15 years, and maybe even sooner, because it is one way to spread the risk in a tolerable way. When insurance companies see that, they will leap in there and grab the profits.

Now, that won't take care of those older persons who don't have children in the workplace or have no children at all. That's why I think that in addition to the private market, and in addition to workplace insurance, there is a role for the Federal Government. That will be as an insurer of last resort as was implied earlier by Senator Glenn, perhaps compulsory national long-term care insurance. It could very well be in this country that we may see that it is more catastrophic to confront the problems of long-term care than it is to confront the problems of reduced income in retirement. How could we add this in on top of Social Security? Well, we are already tinkering with this issue at the edges with Social Security. We have a "backdoor" means test, so to speak, because of the taxing of Social Security benefits under the 1983 amendment. It may be that if we have to make a trade-off choice, we would rather tax ourselves to cover long-term care insurance in this country and gain its tremendous impact for helping out the family, and go to a completely means-tested retirement income program.

Finally, I do think there is also a role for State and local government in some communities. I think we too easily forget that particularly in the service area, excluding the armed services, that the full blown services we have in this country, have all emerged out of locally felt senses of crisis. We did not have police forces in this country at the beginning of the 19th century, or fire services, or public health services. We had night watchmen—I don't think there were any night watchwomen in those days. We had people running around in their pajamas with buckets in the middle of the night. Suddenly, millions of immigrants hit New York City, Boston, and Philadelphia in the space of a few short years and the local taxpayers were faced with what was going on—loss of property from fire, other kinds of property losses, and the night watchman not being able to cry out, "All is well." They said, "Even if we have to pay for it out of our own property taxes, to protect our property, maybe we better put somebody in uniform and have them prepared to deal with these things."

The point is that the notion of what was an essential local service developed from a sense of crisis in specific communities. I am firmly of the opinion that in many communities where parent care is going to become a profoundly felt and widely expressed stress, there may be a strong will to finance supportive services for the family, respite services, elements of the continuum of care, and so on through local taxes.

An aging society, as I suggested at the outset, may be a very dynamic society. The notion of what's essential always changes, and I think we have to be open to that.

So these are a few crazy examples, fresh prospectives, if you will, of how we might deal with an aging society. Whether they are sound or not is certainly open to debate. I have simply tried to illustrate that preoccupation with present policies, the institutional arrangements we have, diverts our attention from other ways of looking at things.

The half life of the absurd is really short these days, and the risk of suggesting absurd things are really minimum. Ten years ago it was outrageous to talk about taxing Social Security. Today it is taxed. Five years ago talk about long-term care insurance was regarded as ridiculous, and yet now both public and private sectors are scrambling to see how this can be done and be more practical.

So I think it is especially important for us to be future oriented in confronting the implications of an aging society. The choices we frame for ourselves are going to do more to shape the nature of justice and the quality of life in an aging society than any sort of policy analyses and extrapolation from existing arrangements. Thank you.

Senator GLENN. Thank you, Doctor. Thank you very much. To follow up on some of your last comments, I think——

AUDIENCE MEMBER. We could hardly understand you in the back.

Senator GLENN. Just let us know if you can't hear.

Doctor, to follow up on your last idea——Can you hear back in the back of the room now?

Dr. BINSTOCK. Can everybody hear me? Thank you for calling it to my attention.

Senator GLENN. Following up on some of your last comments, do you have any ideas, as to where the support for this kind of program should come from?

Do you see the Federal Government playing a major role in this? Should it be local community revenue sharing based? Should the Federal Government stay out of it—which is sort of the trend right now? Do you have any thoughts as to what the capability may be for a local community to handle its own problems? This is something we have to grapple with at the Federal level.

We are seeing the restructuring of some programs. I don't disagree with the efforts to get control of some of these programs back at the local level, or at the State level. I think that perhaps in previous years we went a little too far with some programs—not necessarily those involving the aging. Perhaps some programs went a little too far too fast and should have been tailored back.

Now the pendulum is swinging so much in the other direction. Do you have any thoughts on that?

Dr. Binstock. Yes, I do. We do have a great many local governments in this country, 80,000 distinct units of government and they are set up in many different ways. To say something is going to be handled by local government assumes that all the local environments, structures, and needs are the same.

I think it is very important for us to see the full range of options available to us, that is, private market, local communities and governments; and the Federal Government, certainly, to meet certain needs that are not going to be met by some local communities. This was certainly a clear lesson from experience in the arena of civil rights. If you left some civil rights to the local community, we would have never gotten as far as we have on certain aspects of that.

On this question, for example, of taxing and funding in local communities for long-term care, I think the viability of that will vary from community to community. Now, take a place like Sun City in Arizona. Very interesting example. A lot of healthy people moved out there as young older people. They are aging together.

Now, how things are going to play out there as the high rates of chronic disease and disability start to emerge when these folks are in their late seventies and in their eighties, as more and more of them will be, is going to be very interesting.

On the one hand, their families are not going to be there. Their daughters and daughters-in-law are not going to be there to provide care or to bring about political pressure locally. If there is no family locally to pick up care, or to make demands, communities like that are going to have to spend large amounts or they will have a public health problem on their hands. Whether they are going to react responsibly or not is going to vary. That's why the Federal Government has got to be a backup, and why I think we can't take the issue of long-term care insurance off the agenda of the Federal Government.

On the other hand, I don't see why we should just simply say, "OK, a magic bullet—long-term care insurance by the Federal Government will solve everything, and let's just design the biggest, most comprehensive package we can and fund it." I can't see that. I think we need a sensible, eyes-open approach to take advantage of all the weapons in our arsenal.

Senator Glenn. I appreciate "Sun Cities." But, I am not sure that's going to be an appropriate model for all the people of this country in setting up programs. Its fine for the ones who have enough retirement money to move to Sun City, but I don't think the bulk of Americans can wind up in the "sun cities" of America.

Another thing we have run into is a concern about Medicare—most people are very shocked when they find out how little is covered in the way of nursing home care for the elderly. And that's of a more immediate concern to me right now.

We do have some very immediate problems. People believe they have insurance and, yet, when the first nursing home bill arrives, they find out how limited the coverage is. They are actually sometimes kicked out of nursing homes because of the Medicare requirements for coverage. There are really some horror stories in that area. Have you had some experience with that?

Dr. BINSTOCK. I think your observations are absolutely correct. Most of the so-called medigap insurance is wasted. People have multiple coverage of the same things and can only get reimbursed once. I think there may be a viable role for the Federal Government in constructing and marketing a Medicare Part C which could be a realistic medigap insurance, just as under Medicare Part B we have premiums paid in by older persons to get coverage for Part B.

Perhaps with regulation of that, to see that there isn't abuse, we might have more economics of scale and more honesty and less fraud if medigap is handled through a public entity. So I think that's a practical option and wouldn't need to necessarily cost anything or add to the Federal deficit.

Senator GLENN. Have you conducted any studies or seen any studies about what something like that might cost? We have got to address the bottom line on this these days.

Dr. BINSTOCK. I believe it would be perfectly possible to structure such insurance on a self-sustaining basis through premiums, and there wouldn't be any add-on costs. After all, governments don't need to make profits. Insurance companies do, or at least try to. Government medigap would be competitive in the market.

Congressman LUKEN. You have discussed the stresses that are experienced by the elderly, and you mentioned, I think rather forcefully, the complex situations that they face, HMO's and PPO's and forms here and there, and medigap and so on. Are these stresses in themselves significant due to the complexities of the various programs that the elderly face?

Dr. BINSTOCK. Congressman Luken, I don't know of anyone who has shown that in a scientific study that could be reproduced. But I think that anyone who has worked with elderly clients, or indeed themselves tried to cope with these forms, would take the view that it is stressful. We certainly know that caregiving——

Congressman LUKEN. I am not talking about the single home.

Dr. BINSTOCK. I think I understand. It is this entire range of all these kinds of choices one must make between HMO's, and IPA's, and PPO's, and getting reimbursed through Medicare and medigap insurance, and Medicaid, the issues of Medicaid eligibility, and so on. I mean, how could it help but be stressful?

Congressman LUKEN. I think most people who are in it, the average senior or elderly American who is actually filling out the forms, knows more about the law than the average Member of Congress.

Dr. BINSTOCK. We certainly learn quickly. I know when I fill out my health insurance forms, first of all I need to back off just to cool down a little bit, and then I hang in there, and then I have to make a lot of phone calls the next day to deal with a lot of bureaucrats just to find out what it is we are talking about, let alone what I am entitled to get.

Congressman LUKEN. Yet nobody wants to repeal Medicare or any of those programs. What do we do? I certainly don't want to. People scream about it.

Of course, some of the younger people—and I think that's an issue, too, maybe we should touch on at this point—some of the younger people do a lot of complaining about the very fact of Medicare and Social Security. They believe, so many of them seem to believe, that they are not vulnerable to the vicissitudes of life. They are not going to fall prey to illness or disability or anything of that sort, certainly not any major kind of disability, and, therefore, they would like us to repeal Social Security and Medicare.

Is this pitting of generations one against the other, do you find, Professor, it is a particular problem in our society today or developing into a problem in the future?

Dr. BINSTOCK. I find that it is a potential problem. At the moment journalists, self-styled old age advocates and organizations of the aged, organizations advocating for children, and indeed sometimes—if you will forgive me—politicians, tend to purvey the notion that all seniors vote the same and that they are pitted in an age group conflict against younger people, that they are self-interested and greedy, and there are more and more of them, and they are all going to vote the same.

The truth is that older persons' votes distribute among candidates in the same proportions as middle-age persons. People do not become homogenized politically any more than they do economically, socially, or physically when they reach a certain birthday.

Congressman LUKEN. But you don't know any politicians that want to repeal Medicare.

Dr. BINSTOCK. I know politicians don't like to be differentiated from each other, too far, unless they want to make a run for President.

Congressman LUKEN. When President Reagan wanted to cut back on Social Security in 1982, that's the last time he rated under 55 percent.

Dr. BINSTOCK. That same President prevailed over elimination of the minimum benefit under Social Security which was probably one of the biggest women's issues of our day, and was never even taken up by the National Organization of Women, or the aging organizations in a meaningful way. There have also been all sorts of recent changes in deductibles, copayments and Part B and so on, adversely affecting older persons. But people 60 and over voted for that same President in the magnitude of 64 percent in the last election.

So to make the connection, there aren't any referenda on Medicare. You can't go into a voting booth and cast a vote on, "Do you favor an increase in deductibles?" If you will forgive for me telling you your own business, issues are only a small part of the stimuli people are exposed to in a campaign, and I doubt if they perceive the issues in the same way just because of age.

But to answer your initial point, I think we are being set up and diverted by this age group conflict business from other ways of seeing the issues. Let's take health care.

Everybody is talking about rationing acute health care and worried about the impact of DRG's in terms of "justice between age groups." People write about it this way. They point up the 30 percent of Medicare that's expended on 6 to 7 percent of Medicare eligibles who are in their last months of life. You hear this over and over again. These sorts of things are spurious. There is no better time to expend money for acute health care than when people might prospectively be in their last months of life and, unfortunately, physicians aren't able to tell us yet which persons might be or might have been in their last months if we hadn't expended on them.

I think the issue is truly rich versus poor, not old versus young. We know perfectly well that President Reagan, Bob Hope, Averell Harriman and a number of older people we can name will get all the health care they want even if we eliminated Medicare entirely tomorrow. They would get anything available. Then there is another class of people who would get anything that insurance companies are willing to cover, including organ transplants. The people who can pay those premiums. And then there would be that third class of people who are dependent upon the public. That's going to hold true whether we are talking about old age, middle age, or young age.

So here is a perfect example where we are framing issues in terms of intergenerational equity when the real inequities lie within age groups. How will we ever see the other inequities that are going on if we keep framing issues in terms of intergenerational inequities?

Congressman LUKEN. I don't want to take over the Senator's hearing but I have one more question.

Dr. BINSTOCK. I apologize for getting into making a speech. Excuse me.

Senator GLENN. You described it very well.

Congressman LUKEN. Very cogently—you made a point here that there are choices for middle-aged Americans in caring for their parents. These would be the $30,000 a year high quality institutional care or the warehouse, the Elizabethan poorhouse, or at home. Those are the three choices.

If we take the first two, we have a two-tiered system, therefore, in long-term care. We have done a great deal in this country to eliminate the two-tier system in medicine and health care. There isn't that much difference between Medicare beneficiary and Medicaid beneficiary in the quality of care when it is available. Not that much. I won't tell you that they are the same——

Dr. BINSTOCK. Medicaid is often like the way it was when there were charity cases.

Congressman LUKEN. There is long-term health care. I think what you are stating or at least the conclusion that can be drawn from what you are stating is that we should be moving toward a single-tier system of delivery of long-term care. It is going to be a little more complicated, but that would be an objective. At least that would be the kind of policy that might come out of long-term policy and hearings and considerations like this.

Dr. BINSTOCK. It is a possible implication. One way to do that would be to fund Medicaid up higher and the other way would be to try to do it through regulation. I don't think you would be able to do it by clamping down on the high quality institutions to drop down their level of care.

Congressman **Luken**. I am not comparing Medicare and Medicaid because Medicare can be supplemented. Medicaid, as we know it, cannot. Long-term health care.

Dr. **Binstock**. That's right, but Medicare is short-term and supplemented out-of-pocket, and that's why people are paying the $30,000 to $40,000.

Congressman **Luken**. Not in Medicare very well. The authorities—it would be a little fraudulent.

Dr. **Binstock**. We are just miscommunicating. I met a man the other night who can afford it. He is number two man in his corporation. He is paying $40,000 for his wife's mother out-of-pocket and $40,000 for his mother out-of-pocket and Medicaid isn't involved. That's one choice.

Congressman **Luken**. Medicaid may be.

Dr. **Binstock**. Medicare is only for 90 days or so and then eligibility is going to run out.

Congressman **Luken**. Medicare is part of Social Security. Social Security would be involved, retirement.

Dr. **Binstock**. The Social Security benefits will be going to the individual elderly person, certainly, but they won't cover anywhere near $40,000.

Congressman **Luken**. That's the point. That's the two-tier system. We may very well consider moving for development of Part C or some other aspect of the Medicare. We may move toward a single-tier system.

Dr. **Binstock**. That would be excellent if we could do it through Part C financing.

Senator **Glenn**. Thank you very much. It is very interesting. I wish we had time to continue along this same line. Unfortunately, I have to be the clock-watcher here also. We can continue some of this.

Just one comment before you leave. I would appreciate that when you get some of these other cost studies done, including the figures that may come from the Harvard group that you are working with, if we could, I would like to have that information. If you could let me know when those figures are complete, we could look at this for ideas for legislation that might be possible, once we know what the costs would be.

Dr. **Binstock**. Certainly.

[The prepared statement of Dr. Binstock follows:]

Prepared Statement of Robert H. Binstock, Ph.D.

Thank you Senator Glenn. I am honored to be invited to testify here today.

Since the outset of this decade the spectre of "the graying of America" or "the aging society" has materialized abruptly for most Americans. We have been bombarded by media pronouncements about a variety of issues related to the growing numbers and proportions of older persons. Most of us are becoming aware of the fact that we are spending about 28 percent of the federal budget on benefits for the aged.

As we absorb all the issues that have surfaced and been discussed in recent years, the prospects of an aging society seem foreboding. Among the many anxieties that have been generated are the economic burdens of sustaining a "dependent" aging population; the moral dilemmas posed by the rationing of acute health care on the basis of old age; formidable challenges of financing and developing an adequate and effective range of supportive services for long-term care and rehabilitation of older persons; competition in the workplace between older and younger workers in the context of seniority practices, age discrimination laws, and rapid technological change; and a politics of conflict between age groups. Moreover, the long-time dream that biomedical discoveries might achieve a breakthrough in the lifespan now looms as a nightmare because it may exacerbate all these situations.

Most of the anxieties about the implications of an aging society are based upon extrapolation from our existing public and private policies, and our present social institutions as if they are all going to remain just as they are—on "automatic pilot"—with greater quantities and proportions of older persons simply plugged into these current arrangements. But extrapolation is one of the poorest modes of prediction, because the characteristics of society are dynamic, not static.

THE DYNAMIC NATURE OF AN AGING SOCIETY

The fact is that our public and private policies affecting older persons are being modified continuously in important ways. And even the recurrence of incremental modifications has major cumulative impacts. For example, a series of changes in copayments, deductibles, and reimbursement mechanisms under Medicare over the last few years appear to have had major implications for the costs, organization, and use of health care services for older persons. These changes have not only had considerable effects in revising Medicare cost projections from what they were a few years ago, but have also led, for instance, to the development and proliferation of new organizational arrangements by hospitals that are searching for ways to discharge their patients quickly and responsibly within the context of Prospective Payment Systems (PPSs).

Similarly, social institutions have been undergoing enormous changes. For instance, at a time when many of us have been looking to the traditional structure of the family as an important source of caregiving for long-term chronically-disabled older persons, the structure and nature of family life has been changing continuously. We have experienced several decades of high rates of divorce, single-parent families, remarriage, and unmarried couples living together for extended periods. Improvements in mortality have led to four-generation and even five-generation families becoming more commonplace.

More important to note, perhaps, for the purposes of this hearing today, are the changing roles of middle-aged women. As Elaine Brody of the Philadelphia Geriatric Center and others have pointed out, for many years some 80 to 90 percent of the supportive services to disabled older persons who are not in nursing homes have been provided by their family members, not by formal service systems. Most of these family care givers have been daughters and daughters-in-law—or as Brody has termed them, "women in the middle." But if we consider the changing pattern of labor force participation of women in this age bracket, we cannot rely on a continuation of this level of caregiving from the family, as much as the family may wish to provide it. In the last forty years, for instance, there has been more than a five-fold increase in the labor-force participation rate of women who are 45-54 years of age—from 11 percent to over 60 percent. What this implies, of course, is that many family members who may wish to provide elements of care at home for their elderly relatives may find it impossible to undertake caregiving if they are also working.

If anything, the past few years should have taught us that an aging society will be something very different than a projection of present arrangements driven by mechanisms of demographic change. Life care communities and shared housing arrangements are proliferating. Southwestern Bell is marketing "Silver Pages" telephone books for older persons. Many forms of long-term care insurance are being explored and tested by major insurance companies. Federally subsidized housing projects for "independent living" for older persons are finding it necessary to develop complex service arrangements as their residents age. The world of retirement income is populated by taxes on Social Security, pension integration mechanisms, Individual Retirement Accounts, the Pension Benefit Guarantee Corporation, and many other complexities. Medicare Health Maintenance Organizations (HMOs) have been authorized and launched, and experimental Social/HMOs are being tested. Hospitals are acquiring and developing nursing homes, foster homes, and home care services. One could go on and on.

The main point that I am attempting to convey is that the emergence of the aging society appears to be very rapid, and not at all easy to predict by looking to the past or the present. We need to generate some fresh perspectives for anticipating and coping effectively with the challenges of an aging society. Let me illustrate this, in the few minutes I have left, with some perspectives on the formidable challenges involved in financing and developing an adequate and effective range of supportive services for long-term care and rehabilitation of older persons.

Although many have looked to the families of older persons as a financial or in-kind service solution to the challenges of long-term care, the family is not a panacea. Many older persons have no family. Some families are able and willing to finance care for their parents. Others are willing, but not able to do so. State laws requiring filial financial responsibility for parents' long-term care are proving to be unenforceable. Expectations that families will provide a greater volume of informal supportive care are unrealistic. Family abandonment of older persons is a myth. Indeed, families are probably already stretched to their limits in providing physical, emotional, social, and financial supports for their chronically-ill and disabled older and younger relatives.

It is by focusing on the family, however, rather than on aging and older persons that we may gain a fresher perspective on responses to the challenges of long-term care and rehabilitation in an aging society. For as Brody has cogently observed, parent care is now an "expectable, though usually unexpected," family stress.

If parent care is already an expectable stress, how societally pervasive and intensive will it be in the context of increased population aging—in an aging society? What will be the impact if additional numbers of disabled older persons are added to such care for younger disabled and/or dependent family members?

Perhaps the best prospects for resolving the challenges of developing and financing long-term care and rehabilitation services lie with adult children—particularly middle-income children—who may be the source of substantial demands for new developments. Many adult children—in their 40s, 50s, and 60s—are confronting intractable dilemmas. Faced with the choices of expending (currently) $30,000 a year for high-quality (guilt-reducing) institutional care, or institutionalizing a parent in a (guilt-exacerbating) Medicaid warehouse—the Space Age version of the British Elizabethan Poorhouse—or absorbing the economic, psychological, social and other costs of maintaining a chronically person in their own homes (perhaps while raising children or sending them to college), they may push strongly for new alternatives.

One arena in which this demand could be expressed is the private sector market. Many adult children may be only too happy and able to pay for selected components of a continuum of care, not covered by either public or private insurance, that can make community or home-based alternatives to institutions truly viable. This demand may turn into a significant market for private enterprise.

Another way in which such a demand could be articulated is through collective bargaining efforts aimed at reshaping employee group insurance plans. If care for parents and others is to become a pervasive stress in an aging society, it is certainly conceivable that most of us would like to be insured against the possibility of having to pay extraordinarily expensive bills for long-term care and rehabilitation of our parents. Insurance companies would not have to worry about the issue of adverse selection if long-term care insurance is designed as an indissoluble portion of a group health insurance package. Premiums and benefits for maternity are indissoluble from basic health benefit plans today, regardless of whether it is possible or probable for a given individual in the group to have a child. If long-term care responsibilities are as pervasive as one anticipates in an aging society, its probabilities would distribute among a large labor force grouping in at least a rough approximation of the distribution for maternity benefits.

Still another arena in which the demand for long-term care financing may be felt is national politics, and this may help older persons who have no family. A distinct possibility is a compulsory national insurance program for long-term care, similar to the compulsory program of Old Age and Survivors Insurance. Indeed, if the demand for long-term care becomes strong enough, compulsory long-term care insurance may be considered as an option to replace Old Age Insurance benefits under Social Security. We may, as a nation, come to consider it more important to insure against the financial catastrophes of long-term care and rehabilitation than against reduced income in retirement.

Finally, another way in which the demand for adequate long-term care supportive services may find expression is through the development of locally-felt senses of crisis, and local government responses that finance such services. Crises generate powerful incentives to those who undertake to solve them, namely the people who directly feel the impact of them. If we review the history of the United States we will find that fully-developed services (beyond the token or symbolic level) have not emerged from national initiatives but from local crises. It was the extreme impact of sudden and large waves of immigrants from Europe in the latter half of the 19th century that led to the development of professional police services, fire protection services, and public health services. Similarly, development of community-financed services for an ever-growing chronically-ill and disabled population may be generated through the crises in the lives of individuals and families that are felt profoundly and expressed widely in local communities.

Even when resources are perceived as scarce, the identification of *essential* services is a dynamic process that continuously brings about different answers in the form of resource allocations at the community level. Cohesion in values for achieving such answers is always much easier to achieve at the community level than at the level of a mass society of 240 million persons. And in many communities, where middle-aged children are coping with the dilemmas posed by caring for their parents and other dependents, there may be substantial cohesion regarding the need to pay local taxes for public long-term care and rehabilitation services, and to cut back on other services and facilities.

CONCLUSION

These are but a few examples of how the challenges of an aging society might be viewed from fresh perspectives. Whether these perspectives are sound or useful is certainly open to debate. I have offered them to illustrate that preoccupations with our present policies and institutional arrangements divert us from alternative ways of attempting to anticipate and deal with the implications of population aging.

If we are willing to perceive the future in terms that transcend the existing tapestry of policies and institutional arrangements, we may enrich our perspectives and find practicable options that flow from them for coping with and shaping an aging society. The risks are minimal. At worst such unconventional perspectives may be labeled absurd. And even the half-life of the absurd is very short these days. Ten years ago it would have been outrageous to suggest that Old Age Insurance benefits should be taxed. Today, by virtue of the Social Security Amendments of 1983, they are being taxed by the federal government. Five years ago the notion of extensive and comprehensive long-term care insurance was regarded as impracticable. Today a variety of initiatives for such insurance are being seriously explored and tested in both the public and private sectors.

As we confront the implications of population aging, I believe it will be especially important for us to be imaginative and future-oriented. Ultimately, the creative perspectives that we can generate to describe our choices will be far more important than any data or analyses of existing policies for shaping the quality of life and the nature of justice in an aging society.

Senator **Glenn**. Thank you. Please join us up here. Our first panel is called "The Family of the Future: Society in Transition." We will open with Judge Lillian Kern from the Domestic Relations Court in Dayton. Prior to her election as judge in 1977, she served as assistant prosecuting attorney in Dayton. Judge Kern is active in the Ohio Association of Juvenile Court Judges and she has served as chairperson of the domestic relations committee. She will share her experiences in the courtroom related to women and the elderly in areas such as divorce, alimony, and the impact of family disputes on older women. I believe having input from the judicial system will be especially helpful as we try to identify gaps between current policies and laws and future needs.

Judge Kern, we welcome you. Thank you for being with us.

Also with us is Miss Charlotte Birdsall. Ms. Birdsall is senior city planner and head of the housing section of the Cincinnati City Planning Department.

She is a graduate of Miami University and has a master's in community planning from the University of Cincinnati. She is the immediate past vice president of the Ohio Chapter of the American Planning Association and currently teaches housing policy at U.C. Charlotte, thank you very much for being here.

Congressman Luken had some other commitments this morning. We appreciate you being here.

Ms. Birdsall's areas of specialty include housing policy and planning for "unique" populations, especially the elderly and families with female heads-of-household.

When we were considering a witness to discuss housing issues at this hearing, a number of people we talked with recommended Ms. Birdsall. She is obviously well-respected in the housing field in this community. We look forward to hearing her ideas for meeting the changing needs of our society.

The third witness is Joyce R. Cochenour, who has traveled from Chicago. She is the national marketing manager for Mature Outlook, Inc., which is part of the Sears family of companies.

She is a graduate of the University of Nebraska and began her career with the Allstate Insurance Co. where her work concerned operations, training, and direct marketing. Ms. Cochenour is also a member of the National Council on the Aging. I think it is appropriate that Sears, the top retail corporation in the Nation, is represented at this hearing.

This January they will celebrate the birthday of their first 100 years of serving consumers. Although I don't think there is anyone in our audience who has reached their 100th year, most of us have been shopping at Sears over the years. They began with a progressive view of the American consumer and clearly, 100 years later, are continuing to look ahead at the changing nature of our society.

So, Ms. Cochenour, we look forward to hearing about the corporate view of the American marketplace and what you see.

We will start off with Judge Kern and look forward to your testimony.

STATEMENT OF THE HONORABLE LILLIAN KERN, JUDGE, DOMESTIC RELATIONS COURT, DAYTON, OH

Judge **Kern**. Thank you, Senator Glenn. If I speak too loudly into this, I hope you will let me know because my mother always said that I have the voice that shattered glass.

As I sat here listening to Dr. Binstock and to you, Senator, this morning, I thought you must have been reading my mind. My husband and I are going through what you have been talking about this very week.

My mother-in-law can no longer live without 24-hour care and the costs of that, of course, are going to be enormous. We are working on that over the next 2 weeks intensely. That's not my subject, but I wanted to mention one idea we had.

We both saw a story in the paper about the possibility of introduction into Congress about a bill that would make expenses of caring for an Alzheimer's victim deductible, and we would like to suggest that when the family takes the place of the public institution or of welfare or of Medicaid or Medicare to supplement the income of an infirmed person.

My mother-in-law is a complete invalid. That tax deduction should be available for some or all of that expense which keeps that individual from becoming a public charge. [Applause.]

I want to thank you for inviting me this morning. My remarks will be devoted to the problems of divorced women.

The first problem I always note in particular in dealing with older women who are not apt to get into the marketplace too readily, is that they often have no access to group health, medical or hospitalization benefits. I cannot tell you how many cases come through our court every year where the provider of the health insurance has been the husband, his business or his employer. Seldom, if ever, do I see an opportunity for the wife even at her own expense to continue to be a part of the same group of which she was a part when married.

Individual coverage, as I am sure you are well aware, is extremely costly and the benefits are seldom as good as those available in the group furnished by the employer. Recently, just as one simple example, lawyers told me that they had calculated that to replace the free health benefits she had been receiving would cost $1,800 to $2,200 a year and would not cover everything by any means.

This kind of expense, of course, cuts very deeply into very limited income. I suppose all of you are wondering what about the alimony that women get? A lot of people don't realize that the stories you read in the magazines and press about women able to get everything in divorce are basically untrue. That simply isn't the state of American law for the ordinary woman. People don't have to buy their way out of marriage any more. We have no-fault. No-fault was supposed to reduce the cost of divorce and to reduce the stress and strain of divorce.

In many States, there is complete no-fault divorce so that a party may be granted a divorce whether or not he or she was the aggressor, the wife-beater, the person who was unfaithful or who otherwise caused the termination of the marriage by fault. As an example, anyone can get a divorce in Ohio who has been separated from his or her spouse for more than 1 year.

The only issue then is how are we going to divide the property and how are we going to provide support for the other spouse, the one that is economically disadvantaged, the economically disadvantaged spouse who no longer has leverage in most cases in States where there is no-fault divorce.

In recent years there has been a tendency in courts to pat themselves on the back for dividing property at least equally, recognizing, we say, the contribution of the economically disadvantaged spouse—from now I am just going to say the woman because that's usually the case—recognizing the contribution of the wife as homemaker and caretaker and supporter of the husband.

Unfortunately, this simply isn't enough in most cases for ordinary people. If the wife is an older person in her late 40's or 50's or 60's, the bargain she made was to be cared for in her older years, not to attempt to go out into the marketplace and support herself independently. So she has few skills. In many cases, she has little education and she will not be able to accumulate very much more in life whereas her working spouse will still be able to accumulate property such as increased retirement benefits, savings, real estate, and the like.

I am not going to belabor this, but I do invite the attention of anyone who is interested in seeing some well-documented facts on the new poor, the divorced spouse head of family, to the new book, "The Divorce Revolution" by Lenore J. Weitzman. This lays out the problem in plain and simple language and is based on her extensive research.

Just a word or two more about the alimony. It has gotten really bad press in the last 4 years. At least one State in this Union has declared as a matter of public policy that alimony is against public policy, completely disregarding the fact that an economically disadvantaged wife may now be dumped by the other party at any time in his or her life and particularly when she has no access to any income of any substance whatsoever.

The alimony you read about in the paper, thousands of dollars and jewelry, are not what happens in the ordinary case. What does a woman do if for 30 years her occupation was being a housewife? Prejudice in spousal support is widespread. Only recently a judge of mature years told me that he was opposed to alimony in any amount to anyone even if she were disabled and the marriage was of extreme duration. More importantly, perhaps, half of it isn't paid anyway. Thank you for the time to talk about some of these things.

Senator **Glenn**. Thank you very much. Our next witness is Ms. Birdsall.

STATEMENT OF MS. CHARLOTTE BIRDSALL, CITY HOUSING PLANNER, CINCINNATI, OH

Ms. **Birdsall**. Thank you, Senator Glenn. It is an honor to be here and I am very pleased to have this opportunity to speak. I am going to direct my remarks to areas related to housing—particularly as it relates to two segments of the population. The two groups are older citizens and single heads of household. I think you began illustrating, Senator Glenn, when you talked about Ozzie and Harriett, the fact that the media quite often tells us what is happening to the fate of families.

Not too many years ago we watched "Father Knows Best" and "Leave It To Beaver." These programs have since been replaced by programs such as "My Three Sons," "One Day At A Time," "Good Times" and most recently by a program called "Kate and Allie," which is about two divorced mothers and their children who are going it together to try to survive.

It seems to be common information that the traditional family as we used to see it portrayed has become pretty much a figment of the past. Statistics vary but most agree that somewhere between 7 and 17 percent of households fit the old stereotype of a family in which father works and mother stays at home full time to care for the 2.5 children.

Increasingly, we have women shifting for themselves or for themselves and their family. In Cincinnati, one-third of the households are headed by women. In black families, one out of two households with young children is headed by a woman. These statistics by themselves I maintain are not cause for alarm. Many people automatically assume that one-parent households must be automatically inferior to two-person households. This isn't necessarily true.

Most of us know of families with only one parent at home where the children are growing up well adjusted and healthy. On the other hand, there is an aspect of the single parent phenomenon which gives great cause for alarm, particularly if the single head of households is a woman. That concern is poverty. The impact of being single, female, and the head of a household is illustrated when one considers that this group comprises nearly two-thirds of all poverty households in this country.

What does it mean to the single woman in Cincinnati who is looking for a place to house herself and her family? A typical rent in this region is in the neighborhood of $382 a month for a two-bedroom apartment and $474 for a three-bedroom apartment. If one is only getting $700 or $800 a month, that kind of rent has to be pretty much beyond the realm of possibility. One alternative might be to apply for subsidized housing. However, the public housing waiting lists in Cincinnati can require waiting as long as 3 years for an apartment and, in fact, the lists are temporarily closed for section 8 certificates because they became so long there was no assurance a person's name would ever get to the top.

So the remaining alternatives are often doubling up with family in a situation that isn't really meant for doubling up, living in substandard housing, or in a few tragic cases, ending up as being part of the increasing homeless population.

I would like to mention several options for housing that are currently in existence and discuss additional ideas to consider for the future. One existing federally sponsored program is "Project Self-Sufficiency." In this program, qualified women who are low income and have young children are awarded a section 8 housing certificate. However, they get more than just the housing certificate. They get a whole personal self-sufficiency program designed with their own needs in mind. It almost always includes some form of career counseling, employment training or G.E.D. completion, if that's what's needed. Other services might include preschool or daycare for a youngster, financial or health counseling, transportation, et cetera. For each woman it is different combinations of services—all leading to that overall goal of self-sufficiency.

I can't stress enough the importance of the support of the other participants. Whenever we are talking about redesigning the community, physical restructuring of communities to make the support more readily available to single parents or to any of today's two working parent households, the support network provided by other people, is really just about as important as social services. This is something you often don't get if you are struggling just trying to survive and stay alive. We have found it to be very significant in the projects of self-sufficiency.

Other housing types designed to meet the needs of this growing, single female parent segment range from emergency housing—shelter for someone who is on the street and needs a place to shelter herself and her children—to other forms of transitional housing.

The latter is directed to the person who is in the process of establishing herself as an independent, directed person needing a safe, affordable living arrangement for a period ranging from 6 months to 2 years. I believe there is a great need for some such housing, but it is in short supply. We know that many women remain in abusive situations simply because there is no alternative. Nationally there are some models for transitional housing, but they are rare. The only transitional housing in Cincinnati that I know of is related to our battered women's shelter, and it is very small.

Another more permanent housing type which seems particularly suited to women, although it certainly isn't limited to them, is low cost or limited equity cooperative apartments. In New York and other eastern cities we think of co-ops as being a way to build up equity in the place where you live. What I am talking about here is more a "management style."

It is a way in which the residents take a hand in organizing their home in order to offer a "support system" to each other and keep costs down. There is also, some buildup of equity, but that isn't the low-cost co-op's main intent. Such housing types are fairly common in Canada, but there are none in Cincinnati at this time.

I would like to now talk about elders and the housing needs as we see them for the older population. It has already been pointed out by Dr. Binstock and yourself, Senator Glenn, that the proportion of the elderly is increasing across the country. It is now about 12 percent of the population nationally, and in Cincinnati it is 14 percent. This is probably true in most urban centers.

Senator GLENN. Is that over 65?

Ms. BIRDSALL. Yes, of course if we go down to an earlier age, which I don't consider elderly any more, there is a considerably larger percentage. My own parents have helped me redefine the meaning of growing older. They are part of the population that we were talking about who are active and more vital now maybe than they were in their earlier days; but they are also fortunate in that they can afford a reasonable standard of living and they haven't had any debilitating illnesses.

Our statistics tell us that at any one time no more than 5 percent of elders are living in nursing homes while another 5 percent may be moving to some of these new "life care" complexes that we hear so much about. This suggests that the vast majority of elders are choosing to age in place. I think it is to the latter population that we have to particularly be addressing our housing programs.

In Cincinnati we have an organization called "People Working Cooperatively," which provides major home repairs to low income homeowners. Many of the senior centers offer similar services. For example, young boys may come around and change storm windows for an older person living in his or her own home.

Home sharing provides another option for the older person who does not wish to leave home. A person opens his or her home to another person to help share the expenses.

Shared housing, while sounding like "home-sharing" is actually quite different. In this example, a group of seniors would choose to live together as a family. It can be done cooperatively by the residents or, more often than not, it is organized by some kind of a nonprofit organization. With shared housing—which we have just recently implemented in Cincinnati—usually zone changes and regulations are required. I would like to mention the concept of "accessory apartments" and "granny flats." The latter are a separate little building or cottage that is usually built on the grounds of a larger home. The idea for those is that they can actually be taken down in the future if they are no longer needed for senior housing.

Accessory apartments, on the other hand, are those where you take a large single-family home and turn a portion of it into a self-contained apartment. For instance, an adult child of the family can take over the main house and the aging parent could live independently in the apartment. Unfortunately, that is not currently permitted under many single family zoning codes so it happens illegally. I am of the opinion that we should be encouraging regulations which permit the addition of accessory apartments in a regulated format.

I would like to close by noting that I believe the "bottom line" is the need for much more government subsidy for housing. I am alarmed at the reduced Federal allocation for housing in the proposed budget. This is occurring for both elderly and family housing, though perhaps it is more threatening to the single parent household with low income.

I hope I have illustrated the importance of housing to the well-being of those who are particularly at risk—the single parent and the older woman. Until one can take charge and take care of oneself, one cannot do so effectively for others.

[The prepared statement of Ms. Birdsall follows:]

Prepared Statement of Charlotte (Tommie) Birdsall

THE FAMILY OF THE FUTURE: SOCIETY IN TRANSITION

Thank you, Senator Glenn. I am pleased to have been invited to participate in this workshop which is dedicated to what I consider to be one of the most pressing concerns facing policy makers today—namely the relationship between changing social conditions and changing lifestyles. You are to be commended for your insight into the effects these changes are having today and will continue to have in future years.

There is no doubt in my mind that women continue to be the prime caregivers in our society. Changes in demographics and the increase in the number of employed women notwithstanding, the primary caregiver—and often the only one—is more often than not going to be a woman.

By now it seems to be common information that the traditional family as we used to view it on TV—working father, homemaker mother, and two or three children—all living together in a single family home, is definitely an endangered species. And perhaps it deserves to be so.

Statistics vary, but it is certain that no more than 15%, and perhaps as little as 7 percent, of all U.S. households today conform to that image. What we have instead is a dramatic increase in the number of households with two working parents. Whereas in 1960, according to the U.S. Bureau of the Census, only one in five mothers of a child under the age of six worked, by 1984 more than half of them do. And the Bureau predicts that by 1990 that figure will have risen to 60%.

Increasingly women are shifting for themselves—or for themselves and their children. Divorce rates rose from 47 to 114 per 1,000 married individuals between 1970 and 1982, and the number of single-parent households has risen dramatically during that same period. Approximately two out of five households with children are headed by a woman. Among Blacks that figure is almost one out of two. "American Demographics" magazine tells us that three out of every five children born will live at least part of their lives before the age of eighteen with only one parent.

These statistics by themselves are not necessarily cause for alarm. Although there is a commonly held conviction that one-parent households are never preferable to homes with two parents, common practice is beginning to cause us to give second thought to that belief. The "broken home" image seemed to carry with it a connotation of emotional and physical deprivation, frequently leading to juvenile delinquency on the part of a child and exhaustion and depression on that of the parent. One does not have to be a social scientist to observe that many single parents—both mothers and fathers—are successfully raising emotionally secure children who are developing into productive adults. And frequently they are discovering that, although not without its emotional and social costs, the experience has made them stronger individuals.

On the other hand, there is an aspect of the single parent phenomenon which *is* alarming. That is the tendency for single woman heads of household to be poor. The impact of being single, female and the head of a household is illustrated when one considers that this group comprises fully two-thirds of all poverty households. In Cincinnati that meant that those persons had an annual income for themselves and their children of less than $10,000 in 1980.

What does this mean to the single woman who finds herself faced with the necessity of "taking care—taking charge"? In Cincinnati the "fair market rent" for a two-bedroom apartment was $382 a month in 1982, while for a three-bedroom it was $474. For a family surviving on barely $800 a month, those figures make renting a decent apartment out of the question.

One alternative is to apply for some form of subsidized housing. Unfortunately, in most of the country the waiting lists for subsidies are so long that often the Public Housing Authority simply is forced to stop taking names until the list is reduced to a more manageable size. This leaves the options of paying so much for rent that there isn't enough left for other expenses, or living in housing that is substandard and often unsafe. Frequently even that kind of housing is beyond the means of an individual, leading to the need to "double up" with family or friends or risk becoming a part of the ever-increasing homeless population.

With stresses of that magnitude facing a woman, it is easy to see how her ability to cope as a caregiver will be seriously impaired. Yet it is equally amazing and inspiring to discover how many manage to do so somehow. Although in my job I have nothing to do with home-finding, I have received a significant number of calls from women who are desperately in need of decent housing for themselves and their children.

I will come back to some of the planning and policy considerations which are suggested by the needs of this segment of the population; but first, I'd like to consider the impact of societal changes on today's elderly population.

Just as working women and single women household heads are becoming a significantly larger proportion of the general population, so are the elderly growing in numbers and significance. The number of individuals over the age of 65 has increased from seven percent of the population in 1940 to 12 percent in 1984—and if the trends continue, that percentage will reach 17 percent by the year 2020.

It is inspiring to know vital and active elders and see that aging can be truly a time in life to look forward to. My own parents who are in their mid seventies have redefined for me what it means to grow old. Their lives are purposeful and energizing, and they have much to live for. But they are also among the fortunate ones who are enjoying good health and have the means to live comfortably.

For a significant percentage of the elderly population however, life becomes a time of poverty. In Cincinnati, of the over 48,000 households headed by a person aged 60 or over, approximately 20,000—almost one half—had annual incomes of less than $10,000. This figure might not seem quite so alarming for the retiree who has her/his own home paid off. However, we are all aware of what energy costs can do to a budget, and those costs can be devastating for the person on a fixed income. The elderly *renter* is faced with the necessity of stretching a limited budget to cover the cost of monthly rent—often in an apartment which is dilapidated and unsafe. We have all heard the depressing tales of elders who live as virtual prisoners in their apartments because they are unable or unwilling to go out either for reasons of physical incapacity or because of fear of being attacked. No one should have to endure such circumstances in the final period of their life.

The remainder of this paper will deal with housing-related planning and programs directed to women caregivers—either the single parent or the older person.

Obviously the greatest impact for improving living conditions and the quality of life for both populations would be to increase the supply of affordable, decent rental housing. The current administration unfortunately has reduced funding for assisted housing programs to an almost frighteningly low level. Virtually no new housing for families is being built and only a miniscule amount for seniors. Emphasis is being placed on what is called "moderate rehabilitation" of marginal buildings—usually in the central city. This is fine in many cases, but it eliminates the opportunity for that woman who, though poor, wishes to raise her children in a suburban-type environment or hopes to increase her own job opportunities by living closer to the new industrial areas.

In addition to the "bricks and mortar" of decent housing, the single parent has a need for a support system of people and services. I would like to describe briefly a program of the U.S. Office of Housing and Urban Development (HUD) which, while far too small in scope, offers a model for the type of support of which I'm speaking.

The program is called *Project Self-Sufficiency* and it is directed to single parent heads of household with young children who are poverty level and eligible for public housing. HUD provides a Section 8 housing certificate to the fortunate applicant, and, although that is the strongest incentive, there is much more that is provided.

Each person in the program works with a counselor to design her own "Self-Sufficiency" plan. This almost always includes some form of career counselling coupled with enrollment in a job-training program or completion of work leading to a high school diploma or GED. Other services available may include day care for a preschooler, health screening and treatment, financial counselling, reduced fare for public transit, etc. For each woman it is a different combination of services—all leading to the over-arching goal of self-sufficiency.

I can't stress enough the importance of the support the participants give to each other. As the women attended the three-week "Personal Readiness training" which was required before securing the housing certificate, they helped each other examine self-defeating attitudes and replace them with constructive ones. One of the highlights of my career with the city came several months ago when I attended the "graduation" ceremony in which fifty proud and determined young women walked to the podium and received a diploma and congratulations from the Regional Director of HUD.

Project Self-Sufficiency is not a panacaea. It relies on being able to find willing landlords who will rent to single parents with children. This in itself is frequently an obstacle. It is finally illegal to discriminate on the basis of ethnic origin or sex; however, in most parts of the country it is perfectly legal to deny housing to a person with young children. The program also relies on being able to find employment—especially that with a future. Far too many of the traditional jobs available to women are "dead-end" ones. If a person is to be expected to get off welfare and choose self-sufficiency, she has to be reasonably sure that her hard work and determination will result in being able support herself and her family.

I see a need for a wide variety of housing alternatives to meet the needs of this growing segment of the population. These range from *emergency housing* for the woman who suddenly finds herself and her children in danger of being "on the streets", to *transitional housing*. The latter is directed to the person who is in the process of establishing herself as an independent, directed person needing a safe, affordable living arrangement for a period ranging from six months to two years. I believe there is a great need for such housing, but it is in short supply. Many women remain in abusive situations simply because there is no alternative of which they are aware.

Another, more permanent housing type which seems particularly suited to women, although it certainly isn't limited to them, is *low-cost apartment cooperatives*. A number of models for this housing style are to be found in Canada. Unlike the high-priced co-ops we hear about in the eastern U.S. cities, these projects keep the cost of living manageable for the residents. An individual may invest a minimal amount—perhaps no more than 50 or 100 dollars—for what is sometimes referred to as a "Social Share" in the complex.

The resident can count on getting her initial investment back when she moves out—plus her share of any increase in value of the building. She then participates in management decisions related to maintenance. Usually a camaderie develops among tenants in this process. Not only does a woman obtain affordable housing, she has the opportunity to be part of a network which can provide the support and companionship not readily available in many living situations.

To date, planners have directed more energy to alternative housing arrangements for the elderly. It is interesting to note that, despite the alternative housing types being studied, the vast majority of older adults prefer to remain a part of the community in which they have lived prior to becoming old. Only five percent of elderly live in nursing homes, while another five percent move to new communities. This small number may appear larger because they tend to be more visible.

For those who cannot or choose not to leave familiar surroundings, planners need to devise means to remain "in place" in health and safety.

For instance, for the elderly homeowner on a fixed income, there are home repair programs designed to meet their needs. In Cincinnati an agency called "People Working Cooperatively" provides low-cost *home repairs* and *weatherization* services to elderly homeowners of limited means. They are able to do this with funding from a variety of public and private sources.

Home sharing provides another option for the older person who does not wish to leave home. This is particularly popular for a person living alone. Frequently the sharing occurs informally when a friend or relatives moves in and assumes a portion of the costs of maintaining the residence. But there are formal homesharing programs too in which a homeowner and renter are matched by a central agency. I was told by the director of such an agency in Boston that one of the most successful combinations they discovered consisted of pairing a male student with an elderly woman homeowner. In exchange for affordable housing (a rare commodity in Boston), the young man provided household assistance and companionship. (Parenthetically, it also provided a willing recipient for the "caregiving" services of the older citizen.)

Shared housing, while sounding much like homesharing, is a different type of program. In this situation, a group of individuals may cooperatively decide to live together and share expenses and responsibilities, or, more frequently a separate provider—usually a non-profit—obtains and furnishes a house for the purpose of providing shared living for elders.

Usually a zone change is required plus inspections and, possibly, some sort of certification. Planners have endeavored to minimize regulations for shared housing in order to stress the "family" atmosphere, which is the goal of this housing form. The actual number of seniors living in such housing is still very small; however, I've seen several examples where it works well. For a person wishing to maintain maximum independence who cannot or prefers not to live alone, it is far preferable to entering a nursing home. As housing costs continue to rise, we are likely to see an increase in interest in this option.

Finally, the concept of *Accessory Apartments* and *"Granny Flats"* need to be considered in our consideration of alternatives for living. The latter, despite its catchy name, is rarely found in this country. It is a separate, detached cottage built on the grounds of a single-family home which is occupied by an older relative. Usually the cottage is constructed in such a way that it can be dismantled when no longer needed.

Accessory apartments on the other hand are a relatively common, albeit it often illegal practice. In this situation a self-contained apartment is built into an existing single-family house. This might come about by an elderly widow selling her family home to a married child in exchange for moving herself and her belongings into the accessory apartment and continuing to live there independently. The advantages are apparent for both parties. The senior benefits from the equity realized from the sale of the home. The younger family obtains housing which is probably more affordable than if purchased on the open market. Both households realize privacy and independence, yet the closeness is there—along with the option of continuing to offer care to each other.

Formal opposition to this practice may be forthcoming from neighbors who object to conversion from single-family to two-family status. Consequently, many municipalities have not attempted to regulate this practice through their Zoning Codes. Since the practice is going to continue unofficially—and since it offers one solution to housing the elderly—it seems sensible for those governments to explore ways of assuring some sort of control over appearance and livability.

This paper has touched on a number of physical and social implications related to housing as it affects women and changing life circumstances. Hopefully it has illustrated the importance of housing to the well-being of those who are particularly "at risk"—the single parent and the older woman. Until one can "take charge and take care" of oneself, one cannot do so effectively for others.

Thank you for your attention.

Senator GLENN. Thank you very much, Tommie. We appreciate that very much. The next witness is Joyce Cochenour. We look forward to your testimony.

STATEMENT OF MS. JOYCE COCHENOUR, NATIONAL MARKETING MANAGER, MATURE OUTLOOK, INC., GLENVIEW, IL

Ms. COCHENOUR. Thank you, Senator Glenn. I appreciate being here on behalf of Mature Outlook to share with everyone in this assembly in particular a corporate view of marketing to the 50 and older population.

As recent as 6 years ago, it would have been very difficult to discuss marketing to the mature from a corporate perspective. Most companies didn't have any idea of the potential of the market segment and since the aging of America is a new phenomenon, marketers don't really have the strategy plan developed.

The 1980 census was the instrument that began to effect changes in that attitude and some marketers began to take a look at the statistics. Many myths about the 50 and over population were shattered in that census report. According to the Consumer Research Center, the Conference Board, in a report issued in the summer of this year, the 50 and over population represents $800 billion of annual income and discretionary income is 50 percent of total discretionary income in the United States. That is exciting news for any marketer.

Marketers have found that the dollars spent by older Americans represent 80 percent of the money spent on pleasure travel, 50 percent of the money spent on recreational vehicles and 33 percent of the money spent on lawn and garden products.

They buy 21 percent of all stereos, 43 percent of new domestic cars, 46 percent of all decaffeinated coffee, 25 percent of all cosmetic and bath products, 37 percent of over-the-counter drugs, and 30 percent of all food consumed at home.

Is it wrong for the marketers to direct their efforts to the 50 plus market? Our research has indicated, no, as long as your product meets our needs. Other marketers besides Sears seem to be hearing this message as well. Many corporations today are marketing products and services to older Americans.

In addition to the many companies that work with Mature Outlook, all of the following companies have shown evidence of working in some way to provide special products and services for this age group: Estee Lauder and Elizabeth Arden cosmetic houses, Wilson Sporting Goods, Levi Strauss, Ford Motor Co., Campbell & Co., Denny's Restaurants, Eastern Airlines, just to name a few.

I would like to give special mention to an effort by Southwestern Bell that Dr. Binstock has already referred to. The Southwestern Bell people have issued a publication entitled the "Silver Pages" which is in effect a yellow pages of businesses that provide discounts to people 60 and over in their local community, but in addition the "Silver Pages" contains a local listing of services for this age group that is an invaluable resource.

The National Association of Area Agencies on Aging worked on this section with Southwestern Bell. The "Silver Pages" will reach seniors in 92 major markets in the United States within the next 2 years and projected circulation is 11 million households by 1986.

Synergies between the for-profit and nonprofit organizations have great potential. Here in Ohio there will be five directories for the "Silver Pages": In Cleveland, Toledo, and Columbus this year; and Cincinnati and Dayton in 1986. And for all of those in this assembly, you really need to get a copy of that publication.

In addition, a new organization has been formed called the National Association of Senior Living Industries, a not-for-profit resource network of organizations, professionals and private citizens. The organization was created to enhance skills and understanding of senior adults for those involved in creating, marketing and managing products and services for seniors.

Although this consortium is relatively new, it has great potential for influencing an improved quality of life for the mature market.

I would like to take this opportunity to briefly describe Mature Outlook's role both in the corporate arena and the consumer arena. Mature Outlook was created as a vehicle for Sears to learn about marketing to the newest, fastest growing market segment. We are a for-profit organization. We are nationwide and we do have a membership age qualification of 50 or over.

While providing these distribution channels for the Sears family products, we are committed to providing quality benefits that can save the consumer money and that will provide valuable information. All of the Sears companies, Allstate Insurance Group, Coldwell Banker, Dean Witter Reynolds, and Sears, the Merchandise Group, have products especially for the 50 and older population.

As I stated, many other companies have joined us in providing benefits for our members. I do have literature with me if you want the details on our product.

To maintain the loyalty of our members and the integrity of the Sears family name, we feel research is an extremely important part of our business. It has been a major project for us even before Mature Outlook was brought to market. I will go through this just to give you an example of what corporations are going through to really try to define the needs of the consumer and I am looking forward to a lot of new products that can help people in their older years.

We conducted focus group sessions and a simulator that helped us to design the package in its initial stages. Focus groups, for a quick definition, are typically conducted in local areas and are basically an interview session. Also as a quick definition, a simulator is a description of a product which is accompanied by a questionnaire that allows feedback for the good points and bad points of the product.

Since we were organized in January 1984, we have conducted several research projects with our members. Most often now we use a simple questionnaire format. Response to the questionnaires often runs 25 percent.

We have asked buyers why they join Mature Outlook and nonbuyers what would cause them to enroll. We have asked them as well what of the Sears product discounts they like and what of the Sears product discounts they do not like. We are testing our prices, and we are currently testing to determine what specific benefit information would help us to add new benefits.

Another example is that we would like our members to tell us if a discount at a hotel, for instance, is equally important as perhaps friendly service or coffee in the room or whatever. We are evaluating in this questionnaire our publications, our vacation packages, our hotel discounts and our pharmacy package as well as our Sears discount coupons. We expect that a discount to the older consumer is not what they are actually looking for.

I suspect that friendly personable service is going to be quite high on the list for marketers.

We are also studying how we can reach women in the households in America and interest them in our organization. We have really used our research results to change our product in the past, and will continue to do so in the future to be sure that we are meeting the needs of the older consumer.

We know that they are already influencing the development of a Sears special catalog on home health care. They do have one out there now, but if you look at it, we don't really feel that it meets the needs of the 50 and over population. We are glad to have that opportunity to effect the creative input at Sears Roebuck.

We have conducted an advisory panel, we have participated in a couple of Sears expositions and we take every opportunity we can to talk about our organization. It is part of our plan to create awareness among consumers to develop credibility for our organization and to get feedback on our ability to meet consumer needs.

Our benefit package contains discount coupons on specific Sears products, a half percent discount on loans through Allstate Finance, group insurance products, hotel, motel and car rental discounts, vacation discounts, a low cost mail order policy and publications for active vibrant people over 50.

Perhaps our greatest opportunity, however, is in our ability to educate members through our publications, whether this be in long-term health care or living environments, we have the resources to get that information out to the population.

We have our own member companies' expertise in insurance, real estate, and finance; and I am sure that women need this information drastically. Many have depended on others for this support in times passed, and they can't often rely on that support any longer.

I can share with you some of the attitudes and characteristics that we have discovered. In our earliest research, the 50 and over age group said, "Treat us with dignity. We aren't sitting in rocking chairs on the front porch." Those were shattered myths that I had mentioned earlier. Because these folks are healthier and more active than before, we have used this theme in our advertising, our solicitation materials, and our publications. These men and women are not homogeneous. They have a wide variety of needs and wants. More shattered myths.

Many of them grew up in the depression and are very wise and cautious about how they spend their money. Others grew up in the boom years after the war and are accustomed to spending their money more freely.

Physical health of the individuals also has a great influence on the type of activities that are pursued. We have tried to provide benefits for those who are homebound and benefits for a wide variety of life styles. A variety of wants and needs makes our job as marketers a challenging one.

We have found that this age group is extremely loyal to the store, but once they leave for any reason, it is difficult to get them back. We have found that they are more interested in businesses that offer senior discounts and let them know they are interested in attracting the business. We also know that those under 62 use credit cards while those over 62 in general do not.

It also seems very evident that friendly personal service, as I have mentioned before, is of great importance. A welcome sign in the store or someone to carry out packages all attract the older consumer. They like to be recognized where they shop and they like to shop close to home. We have also found that the topics that are of the most concern are health care and home and personal security.

For a project such as ours, the loyalty to the Sears store and the integrity of the Sears name brands has been extremely valuable. Mature Outlook is excited about the opportunities it has to serve the needs of the public and the opportunity it has to influence the corporate decisionmakers. We are certain the results will be to improve the quality of life for the 50 and over population.

Society is not prepared for the influx of the great numbers of people moving into the age group. With the life expectancy projected to be close to 94 by the year 2000, society should be expected to change its attitude toward health care and living conditions.

Women will be most affected, of course. Because Sears through Mature Outlook is looking at this area, other corporations will as well. The Sears participation has that much clout.

We look forward to the impact we have on discovering the needs of the age group and developing strategies to positively affect quality of life in essence for all age groups. Thank you.

[The prepared statement of Ms. Cochenour follows:]

PREPARED STATEMENT OF MS. JOYCE COCHENOUR

Senator Glenn and Dr. Binstock, I appreciate being here on behalf of Mature Outlook to share with you and this assembly a view of corporate marketing to the 50 and over population.

As recent as six years ago, it would have been difficult to discuss marketing to the mature from a corporate perspective. Most companies didn't have any idea of the potential of this market segment. The 1980 census was the instrument that began to effect changes in that attitude. Many myths about the 50 and over population have been shattered. According to the "Consumer Research Center, the Conference Board", in a report issued in the summer of this year, the 50 and over population represents $800 billion of annual income, and discretionary income is 50 percent of total discretionary income in the United States. That is exciting news for any marketer! Marketers have found that the dollars spent by older Americans represent 80% of the money spent on pleasure travel, 50 percent of the money spent on recreational vehicles, and 33% of the money spent on lawn and garden products. They buy: 21 percent of all stereos, 43 percent of new domestic cars, 46 percent of all decaffinated coffee, 25 percent of all cosmetic and bath products, 37 percent of all over-the-counter drugs, 30 percent of all food consumed at home.

As a result of these findings, many corporations today are marketing products and services to the older Americans. In addition to the companies that work with Mature Outlook, all of the following companies are working in some way to provide special products and services for this age group: Estee Lauder and Elizabeth Arden cosmetic houses, Wilson Sporting Goods, Levi Strauss, Ford Motor Company, Campbell and Company, Denny's Restaurants, Eastern Airlines, just to name a few. I would like to give special mention to an excellent effort by Southwestern Bell. They are issuing a publication entitled "The Silver Pages", which is, in effect, a yellow pages of businesses that provide discounts to people 60 and over in their local community. But, in addition, "The Silver Pages" contains a local listing of services for this age group that is an invaluable resource. The National Association of Area Agencies on Aging worked on this section of the publication with Southwestern Bell. The Silver Pages" will reach seniors in 92 major U.S. markets within the next two years, and projected circulation is 11 million by 1986.

In addition, a new organization has been formed called, The National Association of Senior Living Industries, a not-for-profit resource network of organizations, professionals, and private citizens. The organization was created to enhance the skills and understanding of senior adults for those involved in creating, marketing, and managing products and services for seniors. Although this consortium is relatively new, it has great potential for influencing an improved quality of life for the mature market.

I would like to take this opportunity to briefly describe Mature Outlook's role, both in the corporate arena and the consumer arena.

Mature Outlook was created as a vehicle for the Sears companies to learn about marketing to the newest, fastest growing market segment. While providing this distribution channel for the Sears family products, we are committed to providing quality benefits that can save the consumer money and that will provide valuable information. All of the Sears companies—Allstate Insurance Group, Coldwell Banker Real Estate, Dean Witter Reynolds, and Sears, the Merchandise Group, have products especially for the 50 and over population. Many other respected companies have joined Mature Outlook in providing benefits and services to our members. I have literature with me that will explain the specifics of our program.

To maintain the loyalty of our members and the integrity of the Sears family name, we feel research is an extremely important part of our business.

Research has been a major project for us, even before Mature Outlook was brought to market. Focus group sessions and a simulator package helped us design the product in its initial stages. Focus groups are typically conducted in local areas and are basically an interview session. A simulator is a description of the product and is accompanied by a questionnaire that allows feedback for good points and bad points of the product. Since we were organized in January of 1985, we have conducted several research projects with our members, most often through the use of a questionnaire format. Response to these questionnaires often runs 25%. We have asked buyers why they joined Mature Outlook and non-buyers what would cause them to enroll. We have tested our price, and we are currently attempting to determine specific information on many of our benefits. I can best explain this by giving an example. We would like our members to tell us if a discount on a hotel room is of primary importance, or whether location of the hotel, personal, friendly service, or free coffee service, might be more important. We are evaluating in this questionnaire our publications, our vacation packages, our hotel discounts, our pharmacy program, and our Sears coupon discounts. We are also studying how we can reach the women in the household and interest them in our organization. We have used our research results to change our product in the past and will continue to do so in the future, to be sure that we are meeting the needs of our members. We know we are influencing the development of a Sears special catalog on Home Health Care. We are providing input into products that best meet the needs of this age segment.

We have conducted an Advisory Panel, participated in consumer expositions, and take advantage of every opportunity to talk about our organization to groups and individuals. This is part of our plan to create awareness among consumers and to get feedback on our ability to meet consumer needs.

Our benefit package contains discount coupons on specific products at Sears, a one-half-percent discount on loans offered through Allstate Finance, insurance products for members only from Allstate, hotel/motel and car rental discounts, vacation package discounts, a low-cost pharmacy service, and publications for active, healthy people over 50. Perhaps our greatest opportunity, however, is in our ability to educate members through our publications. We have the member companies' expertise in insurance, real estate, finance. Women need this information. Many have depended on others for this support in times past.

I can share with you some of the attitudes and characteristics that we have discovered. In our earliest research, the 50 and over age group said, "Treat us with dignity. We aren't sitting in rocking chairs on the front porch." Because they are healthier and more active than ever before, we have used this theme in our advertising solicitation materials and publications. These men and women are not homogeneous, they have a wide variety of needs and wants. Many of them grew up in the depression and are very wise and cautious about how they spend their money. Others grew up in the boom years after the war, and are accustomed to spending their money more freely. Physical health of the individuals also has a great influence on the type of activities that are pursued. We have tried to provide benefits for those that are home bound, those that are experienced travelers, and those that are inexperienced as well. The variety of wants and needs makes our job a challenging one. We have found that this age group is extremely loyal to a store, but once they leave for any reason, it's hard to get them back. We have found that they are most interested in businesses that offer senior discounts and let them know they are interested in their business. We also know that those under 62 use credit cards, while those over 62 do not. It also seems very evident that friendly, personal service is of great importance to those over 50. They liked to be recognized where they shop, and they like to shop close to home. Those topics that are of most concern to them are health care and home and personal security.

For a project such as ours, the loyalty to the Sears store and the integrity that the Sears name brings, has been extremely valuable. Mature Outlook is excited about the opportunities it has to serve the needs of the public and the opportunity it has to influence the corporate decision makers. We are certain the results will be to improve the quality of life for the 50 and over population. Society is not prepared for the influx of the great numbers of people moving into the age group. With the life expectancy projected to be close to 94 by the year 2000, society should be expected to change its attitudes towards health care and living conditions for the elderly. Women will be affected the most. Because Sears, through Mature Outlook, is looking at this area, other corporations will as well—the Sears participation has that much clout. We look forward to the impact we have on discovering the needs of the age group and developing strategies to positively affect quality of life, in essence, for all age groups.

Senator GLENN. Thank you very much. Those are excellent statements by all of you this morning.

Judge Kern, we have all heard that grim phrase, "The feminization of poverty." We find sometimes in our society that people may be house rich; a family owns their home, the husband dies and yet the woman doesn't have enough cash income to really maintain the home and maintain a decent life. One of the things that some people have used in some communities is home equity financing. In other words, it is like another mortgage on the house, or letting the house pass to some family member in advance, for cash or other variations along those lines. Have you run into that in your court or had any experience with that?

Judge KERN. I haven't had any experience with the latter, that is, in court except in one case where a very successful business woman was supporting her father by buying his house, but to get back to the first statement about the feminization of poverty, there is no question about it.

I think when we review the indepth research that's represented in the divorce revolution, we see it. It is around us all the time. It has been my attitude that I create new pockets of poverty every time I grant a divorce where there are a number of minor children—if you take the U.S. Government standards.

One thing I would like to recommend if I could: We have seen great interest in Congress in recent years in enforcing child support awards and we are receiving the impact of Congress pushing and shoving the States to get that job done in my own court.

But I would like to suggest something else in addition to that to help the single woman who is now divorced who is not getting support. Right now there are great Federal regulations which require each State to enforce child support and they do give us money. Now, the Federal regulations have been changed to say we can also use that Federal money to enforce alimony so long as there are minor children.

What I am suggesting is why not give us financial incentives to enforce alimony even if the minor children aren't a part of the award. I think that would go a long way to reducing the number of elderly women who find themselves a recipient of family help—if it is available.

Senator GLENN. Federal law regarding that or State law?

Judge KERN. I think both. I think the incentive to collect child support, which is changing the whole face of America's interest in child support itself, came from Congress and the Federal regulations that Congress caused to be developed. There is no question in my mind about that. I can see the huge increased child support that is coming into our county alone since Congress mandated that the States do something about this or lose Federal funds.

Senator GLENN. Is Federal law needed in another area too? Let me ask this: There may be a marriage that lasts 25 years, the woman stays home, she raises the kids and after the kids are grown, there is a divorce. Her job skills are maybe not what they should be at that time, because she didn't go out into the workplace and develop the skills to do the work that she might want to do.

And yet there is no requirement that during the years of their marriage the income was shared for purposes of Social Security. We are just now getting around to making Social Security equitable in terms of income sharing for Social Security retirement payments.

Is there any way that you can see that that can be more equitably dealt with during those working years? Would it require Federal law or State law or what could be done in that area? Do you have any ideas?

Judge KERN. I think Congress took the first step forward when it mandated that if divorced after 20 years of marriage, there would be Social Security benefits. Of course, that becomes very complicated with remarriage. I think that perhaps one way and relatively lower cost to the country would be incentives similar to IRA's.

We now have the ability for a married couple where one of the spouses is not working to have an IRA, and I would see no reason why we couldn't develop some sort of contributory plan so that the spouse who is not working outside the home could build independent benefits or benefits in addition to those minimal ones which might be available to her.

Senator GLENN. I think that would be fine as long as there is a fair income, but where you have a family having trouble making it, asking them to set some aside in case they get divorced later, might get some opposition.

Judge KERN. I would think so. People who are divorced who really have accumulated very little. I suppose we are talking about the ideal situation. I think that the incentive of deductibility, which is a relatively inexpensive device, is very good.

Senator GLENN. Thank you very much. Miss Birdsall, we can't have nursing homes for everybody, nor do I think everybody wants to go to nursing homes or to other retirement places. Most people would prefer to stay in their own community where they are known. They know other people there. They know how to operate and live in that community. It gets to be tragic when they are forced out of that community.

You apparently have been innovative here in Cincinnati in setting up community support efforts. If an elderly gentleman down the street can do carpentry work for a lady, she can provide him some meals, I think these are things that are very forward looking.

Are you having success or difficulties with this? Could you give us a few words on that?

Ms. BIRDSALL. It is interesting to hear you say we are innovative. Sometimes I think we are reactive. For instance, shared housing, which has been in successful operation in many other cities in the country has taken a long time to get started here. But to answer your question, yes, I think we are having good success.

The Area Agency on Aging and Senior Services have been innovative in encouraging people to stay in their homes and making it better for them to do so for a long time. We also have in the housing area, the "Housing for Older Americans Coalition" which has on a number of occasions been in the forefront of encouraging innovation.

I might also mention, Senator, the reverse annuity mortgage that you mentioned to Judge Kern is an option that is being explored further for older people who wish to stay in their own homes.

In a case like that, the owner turns their home over to a financing institution, which then makes a house payment to them on a monthly basis. The financial institution owns the home at such time as the elderly couple is no longer living in it. Although we have not seen much of that technique in Cincinnati, it does offer another option for helping people age in place. The whole concept of congregates in housing is a way in which people can remain as independent as possible as long as possible.

Senator GLENN. Do you tie in Meals on Wheels with medical care to help people remain in their homes?

Ms. BIRDSALL. With remaining in their own home and receiving those services? Absolutely! Previously if those services weren't available, they might have starved to death or else had to move out of their homes. Or they can move into congregate senior apartments as opposed to nursing homes and live relatively independently and get the degree of care that they need, whether it be a home, nurse, home meals served or whatever.

Senator GLENN. Your concept is that you would save the nursing home for those who really need a lot of continual help; not for those who just want another place to live.

Ms. BIRDSALL. Right. You stay as independent as possible. The money saving for the public for lower income people is astonishing. Our metropolitan housing authority has one congregate care facility. They figure it costs about half as much or maybe less for a person to live in that situation than it does in a nursing home.

Senator GLENN. Very good. Ms. Cochenour, in regard to opening up these new marketing areas, when we tried to get several different companies to comment on their efforts for marketing for seniors only, committee staff found them to be reluctant to testify. I am glad you were able to come today and tell us what your company is doing in this area. We know that as people age they often experience changes in their vision, taste, and smell, and in all sorts of other ways, including agility with their hands. These changes may require some special products.

Are companies just now beginning to come around to realizing this? As I mentioned, companies have not been willing to come forward and testify about this—and we tried.

Ms. COCHENOUR. It is true. I think one example is Velcro closing clothing, but Sears offers that through their home health care special catalog. Now they are using Velcro for kids clothing, but there is a great need out there by the older public as well. Sometimes the fingers aren't quite as nimble to reach zippers and buttons.

The Velcro is much simpler. We are having an effect on the Sears project by getting them to include that more prominently in their merchandising. Yes, companies are just starting to recognize this group and their needs.

Senator GLENN. This has little to do with our discussion this morning, but I have been interested in watching the expansion of Velcro into all kind of things. That was a brand new product; right off the drawing boards back in the early days of the Space Program. I don't think we would have been able to have space suits had we not had Velcro to stick everything on; and to stick up on the side of the spacecraft to keep things tied down during weightlessness. Now it is used for everything. It has been interesting to see that.

Ms. COCHENOUR. It is just another example, though, of things that were developed for that space program that are now used by the consumer.

Senator GLENN. I won't make a speech on behalf of the Space Program today. We are dealing with down-to-Earth problems today.

Dr. Binstock, you are the pro. I am sure you have some questions.

Dr. BINSTOCK. You are kind, Senator in letting me share with you in questioning. Your mentioning of the Space Program and all that, I should tell you my 4-year-old daughter wanted to know, What are you going to do daddy, tomorrow? I kept trying to tell her I am going to this hearing of the Senate and so on, and all this was articulated to her, but it meant nothing. Finally, I said, "OK, I am going to meet with an astronaut." That she understood perfectly well. One of the things that interested me in Ms. Cochenour's testimony is how much your particular firm and some of your associates target age 50 as the elderly population.

Senator GLENN. I resented that a little bit.

Ms. COCHENOUR. I didn't say elderly. I said mature.

Dr. BINSTOCK. It is an interesting cut. On the one hand we are moving up the scale now. People are talking about not only the old-old, but also the oldest-old and trying to one up each other in that sense. And here is a movement down the scale toward the mature. I think your point about homogenized milk is well taken, that we must be especially careful.

Might I ask you, Ms. Cochenour, has your firm considered, through Allstate, marketing long-term care insurance?

Ms. COCHENOUR. I have to say that we are very much trying to influence that decision at Allstate Insurance. We know that they have some programs on the drawing board for 1986. There are over 30 long-term care policies out there already. None of them have proven to be successful for insurance companies; so for Mature Outlook, it is going to be a hard sell, but we definitely see the need when we talk to people and we will definitely be in there trying.

Dr. BINSTOCK. Judge Kern mentioned before that one of the problems is the loss of health benefits for a widow or a widower, as the case may be, when the spouse dies. Of course, a related issue is the loss of employee health benefits other than Medicare and Medicaid when one retires.

What does your firm see in the future of health benefits for retirees or for widows or widowers of employees.

Ms. Cochenour. Well, I guess I must say that we hadn't really thought in those specific directions. We feel that our research that we continue to do all of the time will help us pinpoint some of those needs more so in the future than we have been able to right now.

Dr. Binstock. Thank you. Judge Kern, I gather from what you said that poverty among elderly women and women of all ages really is something of a hidden time bomb which can explode without notice. You mentioned the experience with health, as I just recalled.

Do you have any experience with the issue of the election of private pension benefits being undertaken by one spouse—particularly the male—without the female even being consulted on this, and what are the implications?

Judge Kern. Yes, I do and all of it is sad up until Congress gave us the authority in States to issue the so-called qualified domestic relations order which basically is an order to the provider of pension benefits to sequester a certain portion to the divorced spouse and also to enforce those elections which may have been ordered by the court.

Prior to that time, it was not unusual at all for persons being divorced to elect someone else to be a recipient of any after benefits that they might have. You know, in this, Doctor, in this whole area of pension benefits being divisible in divorce is something in the future shock range. It has only been since about 1976 or 1977 that courts generally have been aware that this now is an asset of the marriage.

So there are a lot of women out there still whose husbands kept the pension benefits and in many cases it wasn't even an offset by virtue of offset of the family home or other assets against his keeping those benefits.

Dr. Binstock. Just a brief followup on this. Even without the issue of divorce, let's focus on the death of a spouse. This question of somebody moving into retirement and being able to elect full benefits with no benefit for the surviving spouse, as opposed to a 70 percent benefit that would go on until the death of both spouses, whichever one may survive the longest. Have you had any experience indicating the extent to which husbands go for this 100 percent benefit without any thought at all regarding the total loss of benefits for the widow?

Judge Kern. Not a great deal in the court itself, but personal, yes. My mother-in-law's pension when my father-in-law died, his pension died with him, and which is one of the reasons that my husband and I are so interested in this area and that is not uncommon at all.

Only I think perhaps looking down the road, there may come a time when we may have to mandate, envisioning that women outlive their husbands by at least 8 years, we will have to envision perhaps mandating that a certain portion of that income be set aside rather than making it permissive.

Dr. Binstock. If I have time, Senator, for just one brief question of Miss Birdsall. With respect to those units of federally subsidized housing that were built before the notions of congregate services and perhaps infirmaries or semi-attached nursing homes and so on came into being. As the residents of the apartment units age, do you have any experience with how the management is handling such issues as "When is Mrs. Jones not coming back any more?" Not because of death, but because of chronic disability and the place not being equipped to provide the appropriate kind of support. Do committees make such decisions? Professional committees? Are these issues swept under the rug?

Ms. **Birdsall**. Unfortunately, I don't have much personal experience, but I certainly see that this must be a very sensitive and crucial kind of decisionmaking. I will say in our shared housing for elderly, when we were devising the criteria, one of the things that we stated was that a resident should identify a person in her or his family who would help to make such decisions and there would be a contract signed each year that would take a look at how a person is managing in that setting. So we would try to involve the resident in that decision. Unfortunately, I am sure often the resident cannot or will not be capable of an objective decision as to when another living arrangement is indicated.

I think it is probably a problem in all the life care settings. When it is time to make that change—to a more restrictive living situation—it must be traumatic.

Dr. **Binstock**. It is not such a problem, in my understanding, in a life care community that has a 40 bed infirmary, and 300 occupants. They implicitly know that 20 of those 40 beds are in fact nursing home beds and the other 20 are infirmary beds. They can play it by ear, so to speak. But when you have got this long waiting list and Mrs. Jones is off in the nursing home recuperating, it must be very difficult to come to the decision of when her apartment is vacant. Thank you.

Senator **Glenn**. Good. Thank you, Doctor. Just one item of followup and then maybe we will be back on schedule. The ability to take care of oneself in our senior years is basically a matter of money. That's first and foremost; it is ahead of everything else.

If we don't have adequate amounts of money ourselves, it becomes a community or family responsibility—that's what we are talking about. That's the reason this whole pension issue is of such tremendous interest to me, because too many times women have been frozen out of the pension benefits.

All too often, there was a divorce or the pension plan only covered the husband for as long as he lived and beyond that, it terminated. That was it. So she is left out in the cold. That's a tough one. We have a lot of situations like that.

Many pension plans which were inadequately funded have left people high and dry when they thought they had a pension coming. They found that the fund was not there because the company went down the tube or was bankrupt, or whatever, and the pension fund had not been adequately taken care of. So, there is that problem, number one, which leaves the couple without the retirement income they expected.

Then, number two, there is the frequent problem that the pension benefits are not passed on to the woman or are not shared equally with the woman. I have given thought as to—and we have talked about this—whether there should be some sort of program for pension rights in which the pension money was paid into something like the Federal Deposit Insurance Corporation or the FSLIC. This could be like what we have for banks and savings and loan institutions. Cincinnati is a good place to talk about that; you have had some experience along that line recently.

First, the notion would be that you pay into some kind of guaranteed fund that ensures that the pension is going to be there. Second, there need to be an equitable sharing between the two spouses on this in some way. Do any of you have thoughts regarding going in that direction?

Judge KERN. Just very briefly, I know we could discuss this hour after hour because it is very complex, very complicated as to making portability of pension rights, which is what you are talking about, if you put it into a guaranteed Federal system of some kind. Even the unions are not all for that because they want to control their own pension plans to some extent.

Senator GLENN. You get opposition from business and labor both, but in making sure that every person is guaranteed what they have earned, it seems to me we are going to have to move to something like that in the future.

If you move to that kind of a system, then you can include in that system, a spouse or rights of the guaranteed pension that you have paid into from whatever source. You could work for six different companies and as long as whatever the pension rights were, they are negotiated and then taken care of in a guaranteed system. Then you can break down that kind of a thing.

Then it gets extremely complex and multiple divorces and remarriages. It really gets to be a mess. Do you have any thoughts how we straighten that out?

Judge KERN. I think the idea of a central fund may be one of the solutions. I get a lot of flack from my business friends as a result of the qualified domestic relations order enacted in Congress.

One local, active small businessman said to me, "What are you people doing with my pension fund? One of my employees is getting a divorce and he tells me that I have to do thus and so." It is very difficult to explain. The centralization of this in a way so that he did not have to deal, or she, with the problems that you are talking about, the multiple sharing of this.

It is not as difficult to share as you might think. For example, with military pensions, after McCarty was taken care of, we do sharing with the numerator of the fractions being the number of years of marriage and the denominator is the pension earned. If those were different, we create a fraction and then you split that between the two spouses. Then we are able to make the order.

I don't think it is difficult mathematically. The paper work for the ordinary person and for the ordinary smaller pension fund might be extremely long.

Senator GLENN. OK. Doctor, do you want to comment on that? You must have thought something about this here.

Dr. BINSTOCK. Yes, Senator, I think what you suggest is very sensible. An expansion of some of what is done under the Employee Retirement and Income Security Act and the Pension Benefit Guarantee Corporation, but done in such a way with built in protections with portability, with spousal rights, and with nonmanipulation of pension funds would be terribly important.

My impression is that firms are currently using their pension funds not illegally, but in very problematic ways for the prospective pension recipient in that they are using pension funds to finance their corporate operations. This is in turn putting a great deal of stress on the Pension Benefit Guarantee Corporation. So I suspect the time is ripe for a fresh look at new legislation.

Senator GLENN. That's an area I think is going to be complicated enough. We are going to have to have a lot of hearings on that before we draw up any legislation. I think it would solve a lot of problems if we went that way. Certainly it would be far, far more important to women than what happens now in too many of these pension cases where, as you said, the pension runs out when the husband dies. As a result, the woman is left with nothing unless she has family to pick up the slack or partial Social Security. We thank you all very, very much. This has been very interesting.

We will proceed to the next panel. One thing I would like to ask of those of you testifying today: if we do have other questions from members of the committee after they and their staffs have reviewed today's testimony, and we submit them in writing to you, I would appreciate it if you would furnish us with your answers. The questions and answers will be included in the hearing record along with your testimony today. Thank you very much. [Applause.]

Our second panel is called "caring and coping." It will focus on the problems of family caregivers, the majority of whom are women, as we have said before, and often these are in effect, "women in the middle." They are juggling the care of their children and disabled parent or spouse and a career all at the same time.

Before we begin, I would like to mention an important new publication of The National Council on the Aging entitled "Idea Book on Caregiver's Support Groups." It includes a listing of support groups throughout our country including 12 in Ohio, 2 of which are here in Cincinnati.

There are flyers about this book on the publication table just outside the door. We would appreciate it if you would take one of the flyers about that particular publication.

To open our second panel today, we have Mrs. Bernadine Tatman of Cincinnati. Mrs. Tatman grew up in Cincinnati, became a registered nurse, married, and raised 10 children—a large family.

Her husband's job took the family to Virginia where she lived until 1981. In 1981, she moved back to Cincinnati to live with and care for her elderly mother and retarded brother.

We have asked her to share her story so we can better understand some of the difficulties. Mrs. Tatman will also tell us about the assistance she receives from her family, friends, neighbors and the community in dealing with other overwhelming responsibilities.

Let me also add: When we were looking for family caregivers to testify today, we had no trouble finding people to fit the bill, but as you will hear from her testimony, Mrs. Tatman is a special person. There are thousands more like her coping with the responsibilities of being a family caregiver.

Some of them are with us today in the audience. Others wrote to me telling me that they could not attend the hearing because they could not leave the house to come to the hearing today, because of their responsibilities in caring for someone at home.

Mrs. Tatman, thank you for making time in your busy schedule to be with us today.

STATEMENT OF MRS. BERNADINE TATMAN, FAMILY CAREGIVER, CINCINNATI, OH

Ms. TATMAN. My name is Bernadine Tatman. My two brothers and I were raised in Deer Park, Ohio. I reside there today with my 88-year-old mother and 65-year-old brother.

Growing up during the depression, we learned from my hardworking father and very thrifty mother the value and importance of economizing almost to a feeling of guilt when spending, a factor in some instances that I passed onto my children. Our childhood was a happy one.

After high school, I entered the Cadet Nurse Corps Program. Nurse's training required a form of self-discipline that for all practical purposes has been a help to me throughout my life.

My studies completed, I went to work at the VA hospital in Dayton. When World War II ended, I married at age 25 and, as expected of married women in that day, stopped working and started raising a family. We soon had five children.

My husband was a carpenter and we lived near my family. In time, my husband obtained a civil service position as an Alcohol, Tobacco, Firearms revenuer, and we were transferred to a small town in Virginia. His work forced him to be away a good deal of the time. The children kept me confined to the house and in new surroundings away from my family and among strangers. It was quite an adjustment for me. I had not worked for 14 years, but began working a few days a month in a doctor's office to help pay medical bills.

Within the next 9 years, there were five more children. After the 10th child was born, it was necessary for me to work full time and a position as a director in a friendly rural nursing facility became available. This was a time of hard work and involvement in children's activities, but we all grew to love small town living. My father died in 1963 leaving mother a widow at age 66.

From that time until 4 years ago, she independently cared for herself, my retarded brother, and managed the household and finances very well. She enjoyed senior citizens programs, church, and the company of neighbors who gave her great moral support.

In some ways, her life expanded far more than in her younger years. Because of caring for my retarded brother, she had practically no social life. She has always been extremely protective of him and his feelings. He came first, which was fine.

Shortly after mother became a widow, my husband was transferred to Virginia. Because monetary needs increased as the children grew older, it was necessary for me to continue working. The challenges of schedule, school, house, children's jobs, and transportation was sometimes monumental.

During this time our 14-year-old son was killed in an accident.

My husband continued to be away for long periods and gradually ceased to accept any family responsibility. He divorced me and re-married. Five children were still at home. This was a most difficult time and a very crucial time in the children's lives.

When my younger brother, who lives in New Hampshire and I visited home in 1981, it became very evident to us that mother could no longer continue independently in the house. We definitely did not want mother and Bill to go to a nursing home, and after much discussion, though I had just received a promotion, I took early retirement from a Norfolk city hospital and moved home to care for my mother and Bill. Immediately preceding the move to Cincinnati, my 24-year-old son died.

My move here was with the intention of keeping house and working part time. I left two children still at home. Within a month, mother became very ill and unable to care for herself and could not be left alone.

Though I had tentative plans of returning to Virginia at some point in the future, I realize now that this would not be possible and disposed of the house and furnishings, closing that part of my life.

This decision has been hard on my children, but it has made them more independent. Since I was no longer available in times of crisis, they help each other and have drawn closer.

In the past 4 years, mother has had nine hospitalizations. Her care and Bill's guardianship have become the center of my life. There was a 6- to 8-month period of time I did not leave the house except for church and the grocery.

Then a loyal friend of mother's who had previously cleaned for her began to sit with her most Thursdays giving me a day off to visit friends, the library, and pursue my interest in geneology.

Last year I went home to see my family for a week, having obtained a lady recommended through a church to stay with mother and Bill. She left after the first day. In her words, "She couldn't take it." The neighbors did not want to spoil my vacation and made up a schedule so that mother and Bill were cared for round-the-clock.

Several months ago, a neighbor who works for the Council on Aging told me about Respite Care for Seniors. Through a series of near miracles, a small insurance payment received after my former husband's death and an opportunity to accompany my daughter, I had the thrill of a trip to England. This would not have been possible without Respite.

A careperson was carefully chosen who was able to adapt to the many needs of mother and Bill. Mother is apprehensive when I leave. I returned to a serene, neat household. For me, this was my one and only lifetime splurge, but I now realize the change was a good mental health break for all of us.

In the event of my mother's death, I will continue to care for my brother, but will not hesitate to call on my younger brother for assistance. My biggest concern is that we could not maintain our present lifestyle, simple but comfortable, without mother's income.

Each year I must remain out of the work force, my earning power decreases. Will I be able to get a job again at my age when and if it becomes necessary? Who would care for Bill and understand him? Would I be able to afford day care for Bill?

The community of Deer Park has many elderly residents. They are hard-working, independent people. Many are neighbors of mine. Several are of advanced age and live alone. Several have children living out of town and we all try to help each other.

What happens when this is no longer possible? Who can they turn for assistance and will it be there for them when needed?

Thank you for the opportunity to share a part of my life and my family concerns with you today. I did not want this testimony to sound like a pitiful pearl story. My role as a family caregiver has been my choice and despite the difficulties, I am proud of the progress my children have made on their own initiative.

I'm grateful to Respite and the many caring people out there. It is my hope that agencies that assist caregivers are able to continue and thrive. More support will be needed in the years to come because there will be more older people living longer. I hope, if needed, Respite will be available for you.

It has been a godsend for me. [Applause.]

Senator **Glenn**. Ms. Trenkamp moved to Cincinnati from England in 1959 and her work has spanned the age spectrum. She is the mother of four children. She contributed a great deal to the well-being of our young. She is a former staff member of the National LaLeche League and was a founding member of a shelter for abused and neglected children in Kenton County.

Her commitment to addressing the problems of those with Alzheimer's disease is based on personal experience. Following the death of her father from this tragic disorder in 1983, Ms. Trenkamp began volunteering with the Cincinnati association.

When the association had grown to the point where they could sustain a professional office, she was asked to be their first executive director. The growth of the National Alzheimer's Disease and Related Disorders Association and the dramatic increase in awareness of this issue has been remarkable.

We are very pleased that you could join us today, Ms. Trenkamp. We look forward to learning more about the issues with which you deal daily and your thoughts about how we can effectively address these issues.

STATEMENT OF MS. DIANA TRENKAMP, EXECUTIVE DIRECTOR, ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION, CINCINNATI, OH

Ms. **Trenkamp**. Thank you, Senator Glenn. I would like to just take a few moments to tell everybody a little bit about what the association does and about our scope.

The local association was founded in 1979 by family members of Alzheimer's patients. It had four goals at that time and we continue to have those four goals. They are the goals of family support, education, advocacy, and research.

The association has grown from the original four families to approximately 2,500 individuals. Of these two-thirds are family members or friends of patients and the other third are professionals. We respond to 100 calls a month. In order to meet goals of the association, we have programs which we operate. We have an information and referral service through the office which operates Monday through Friday, during regular business hours.

We have a very active speakers bureau which makes about 10 presentations a month, and we also publish a quarterly newsletter. The other goals are met in other ways. Our advocacy efforts have been rather low key so far in the Cincinnati area.

We are part of a statewide advocacy group which recently came into being which is made up of various chapters of the Alzheimer's Disease and Related Disorders Association. We advocate for patients and family whenever there is a possibility of help.

In the area of research, we do not at the local level fund any research projects. We do support our national effort. The national organization funds mainly research projects through its programs, but we do contribute in one significant way. We are very active in advocating autopsy which provides final diagnosis of Alzheimer's disease and also provides brain tissue for ongoing research at the University of Cincinnati.

Within this chapter area there are approximately 11,500 people suffering from Alzheimer's disease or a related disorder. That's a very conservative estimate, too. It is difficult to comprehend the enormity of the tragedy, but I may make it easier to grasp if I share with you the situation in which four caregivers find themselves.

Mrs. Tatman is another contributing person to this. I have listened to what she is doing, and I know how difficult it is. She makes it sound almost easy, but I know the pressures because I talk to such people every day.

The first person I would like to talk about is a woman whose name is Louise. She is 38. Her husband Michael is 44. They have five children, four of whom still live at home. The children are 14, 16, 18, 19, and 21.

Michael has suffered from a severe memory loss problem for 2 years. A year ago he was forced to give up his job as a lab technician. He has seen a succession of doctors, family practitioners and neurologists, but physicians are reluctant to diagnose Alzheimer's disease in such a young man. They tell Louise to keep hoping, but she watches Michael's deterioration and she knows what lies ahead for him.

Her mother, who is 65, suffers from Alzheimer's disease and is a resident of a nursing home. She can feed herself with help, is becoming incontinent and there are days when she doesn't recognize Louise at all. She thinks she is her sister. She was diagnosed 10 years ago at the age of 55. Now at the age of 65 she needs round-the-clock care which has to be provided in a long term care facility.

Louise realizes that Michael will eventually need the same kind of care. She tries to make the time left to him as meaningful as possible. He still enjoys some of the activities he enjoyed before his illness. She knows the time will come when he will not even be able to take pleasure in such activities.

It has been very hard for their children to comprehend the changes in their father, the reversal of roles which has forced them to change the way they look at their father. They continue to include him in their life as much as possible, but it is increasingly difficult to communicate with him in a meaningful way. The father they once knew and loved has become a distant stranger.

He was a gentle man who has now become combative and subject to outbursts of rage which are frightening to his family, and they have developed a system of hand signals to stand behind him and signal to one another to try and head off some of the more violent confrontations.

It takes all of Louise's strength to cope with Michael's physical needs. He needs direction for even the simplest of tasks. Before his illness he was a handyman in the house and maintained his own car. He is no longer able to perform any of these tasks. He receives Social Security disability benefits. However, when these were granted, he lost the disability allowance which he received from his former employer. They gave with one hand and took away with the other.

Louise is unable to work because of the burden of caring for Michael. It is also difficult for her to attend the chapter meetings. His illness has begun to isolate her and has forced them into very severe financial difficulties. They have spent all their savings in the last 2 years.

The greatest loss Louise feels is the loss of companionship. They were a close and loving family. Her children are her strength, but they cannot fill the void left by her husband's illness and she grieves for the loss of the relationship they once had and she fears for the future.

Agnes was diagnosed as having hardening of the arteries in 1980 when she was 64. Two years later she was reevaluated and a diagnosis of Alzheimer's disease was made. In 1981 she was left alone in her home when her youngest son married. Her family realized that she could no longer live alone and she was brought to live with her daughter Mary and son-in-law John. She still lives with them.

At first they were able to use a part-time sitter, someone who stayed with Agnes late in the afternoon when she became extremely agitated in a condition known as sundowners syndrome. She became very agitated this time of day.

Senator GLENN. Just a second. Can you all hear OK?

Mrs. TRENKAMP. Sorry. Agnes now requires constant supervision. Patty was hired as a companion. She is paid $130 a week and cares for Agnes during the day when Mary and John are working. There is no reimbursement from private insurance or Medicare for such custodial care.

She now weighs 85 pounds. When she was well, she weighed about 120 pounds. She still eats voraciously although all her food has to be blended to prevent choking. Because of her constant pacing, she wears out a pair of Nike shoes in 6 weeks.

She is sometimes incontinent especially at night and requires expensive diapering and special waterproof draw sheeting. Judge Kern pointed out pension rights and this pertains to Agnes because she was divorced from a Federal employee 15 years ago and lost her rights to his pension.

She worked for a relatively short period of time until she was fired because she could not make change in her job as a bakery clerk. She draws a very small Social Security pension. It does not cover the cost of her care at home and faced with the prospect of placing her in a long-term care facility in the future, Mary and John constantly worry about how they will afford such expensive care. They are very active members of the association and work to change a system which does not seem to work when they most need it.

The third family is Leah who is 74. Her husband Harry is 77. Harry was diagnosed as having Alzheimer's disease 6 years ago. Leah has struggled to care for him at home for all these years. She is a small woman. She is only about 4 foot 10 inches.

She does not have use of her left arm because of surgery and her care of Harry has been especially difficult because he is a large man. He is also extremely combative. They have received some help in the form of Meals on Wheels, but there was no day care or respite care to provide a break for Leah from the burden of caring for Harry.

She was unable to attend any support group meetings where she might have been able to share some of the burdens with other caregivers. Her contact with other caregivers was through the association's quarterly newsletter. She has finally faced the inevitable and will place Harry in a nursing home. She will be able to pay for his care until his funds run out. She is broken hearted about placing him in a care facility.

Marjorie is 59 and her husband is 61. He was diagnosed as having Alzheimer's disease in October of 1981. He is a retired Federal employee and veteran and has received care through the VA facility in Cincinnati.

He still manages to care for himself quite well, but he does require special help. He is no longer able to manage his dental care and he has to visit a dentist every 2 months for special preventative care. He is extremely restless at night which means his wife is disturbed. He requires constant supervision, and although he is still verbal, he is no longer able to communicate in a very meaningful way.

He and Marjorie enjoyed an active social life and when he traveled in the course of his work, she enjoyed friendships and her volunteer work at the local hospital. Alzheimer's disease has changed all that. He can no longer take part in social activities so Marjorie is becoming more and more isolated.

She has found her local neighborhood support group of tremendous help and also finds it gratifying to be able to help other caregivers. She is grateful for the Salvation Army Day Care Program which Doug attends 3 days a week. It gives her time to run errands and catch up on her housework. She is also grateful for a new health care policy which provides some reimbursement for home health care because she knows that she will soon need some help if she is to keep Doug at home with her.

Doug's mother does provide some respite. Marjorie worries about financial matters. She has an annuity which will help to pay for Doug's care, but all the careful planning they did together before his illness will not protect her from the enormous cost of nursing home care when that becomes necessary.

In summary you should know that these are only four cases. These are some of many that exist in this community and all over the country. They show wives and daughters and mothers caught up in the care of parents who no longer are able to express their appreciation for the gentle loving care they are receiving.

Women have traditionally been caregivers and nurturers in the society. As mothers we find joy in mothering children for they have the promise of independence and adulthood but for the care of Alzheimer's parents, there is a certain knowledge that tomorrow will bring a further decline towards infancy.

We cannot change that but we can provide support for these caregivers, an effective program of day care with transportation and in-home respite care can lift some of the burden.

This will enable families to care for loved ones in their own home and postpone the often inevitable placement in a long term care facility.

The Alzheimer's Disease Association of Cincinnati, in partnership with our local association, supports efforts to provide such coverage through insurance policies at a private level and also State and Federal legislation. I thank you for this.

[The prepared statement of Ms. Trenkamp follows:]

PREPARED STATEMENT OF MS. DIANA TRENKAMP

I am honored to have been asked to testify at this hearing on "Women in our Aging Society: Family and Community Life" and would like to address the topic of Alzheimer's disease and related disorders and the women who are caregivers in this devastating situation.

My name is Diana Trenkamp and I am the Executive Director of the Alzheimer's Disease Association of Cincinnati, Inc., which is one of more than 140 Chapters and Affiliates of the Alzheimer's Disease and Related Disorders Association, headquartered in Chicago, Illinois. This Chapter was founded in 1979, by family members of Alzheimer's patients, with the four goals of family support, education, advocacy and research.

The Association has grown from the original four families to a mailing list of approximately 2500 individuals. Of these two-thirds are family members or friends of patients and the remainder are interested professionals. We respond to approximately 100 calls a month for information and referral and mail basic packets of information to most of those callers.

The territory assigned to us, by our National Association, includes 11 counties in Ohio, 7 counties in Northern Kentucky and 5 counties in S.E. Indiana.

The four goals of the Association are met in the following ways:

Family Support and Education: We maintain an information and referral service through the office from 8:30 a.m. to 4:30 p.m. Monday through Friday. Neighborhood family support groups in twelve locations provide an opportunity for sharing of concerns and mutual support. Monthly Chapter meetings are informational in nature, featuring speakers with special expertise in areas of interest to families coping with dementias. Our Speakers Bureau members make an average of 10 presentations a month to nursing homes, professional and civic associations, senior citizen groups, medical and nursing classes and church groups.

Advocacy: Our advocacy efforts have been directed at the various legislatures and at the community-at-large. We speak for the needs of families and patients whenever the opportunity presents itself.

Research: The Association supports medical research through financial contributions to ADRDA National which, through a program of grants, funds many research projects. We also present frequent programs on the importance of autopsy, both as a opportunity for families to receive the final, definitive diagnosis and for researchers at the University of Cincinnati to have brain tissue made available for their various projects.

Within our Chapter area it is estimated that there are 11,500 people suffering from Alzheimer's disease or a related disorder (and that is a most conservative estimate). It is difficult to comprehend the enormity of this tragedy but it may make it easier to grasp if I share with you the situation in which four caregivers find themselves.

1. Louise is 38, her husband, Michael is 44. They have five children, four of whom still live at home. The children are 14, 16, 18, 19 and 21. Michael has suffered from a severe memory loss problem for two years, a year ago he was forced to give up his job as a lab technician. He has seen a succession of doctors, family practitions and neurologists—physicians are reluctant to diagnose Alzheimer's disease in such a young man, they tell Louise to keep hoping but she watches Michael's deterioration and she knows what lies ahead for him.

Her mother, who is 65, suffers from Alzheimer's disease and is a resident of a nursing home, she can feed herself (with help), is becoming incontinent and there are days when she doesn't recognize Louise as her daughter, she thinks she is her sister. She was diagnosed 10 years ago at the age of 55, now at the age of 65 she needs round the clock care which has to be provided in a long-term care facility.

Louise realizes that Michael will eventually need the same kind of care, she tries to make the time left to him as meaningful as possible. He still enjoys some of the activities he enjoyed before his illness and Louise tries to continue those activities when possible, she knows the time will come when he will not even be able to take pleasure such outings.

It has been difficult for the children to comprehend the changes in their father, the reversal of roles which they have been forced into. They continue to include him in their lives as much as possible but it is increasingly difficult to communicate with Michael and the father they once knew and loved is being replaced by a stranger. A gentle man who never disciplined them now can be combative and confrontational. He suffers from outbursts of rage which are frightening to his family and they have developed a series of hand signals to try and head-off such confrontations.

It takes all Louise's strength to cope with Michael's physical needs, he needs direction for even the simplest of tasks and assistance to complete those tasks on many occasions. Before his illness he was a handyman in the house and maintained his own car—he is no longer able to perform any of these tasks and the burden falls on his family to manage without him. He receives Social Security Disability benefits, however, when these were finally granted he lost the disability allowance which he received from his former employer. Louise is unable to work because of the demands of caring for Michael and it is also difficult for her to attend support group or chapter meetings. His illness has begun to isolate her and has forced them into severe financial difficulties, they have spent all their savings in the last two years.

The greatest loss Louise feels, however, is the loss of companionship—they were a close and loving family and her relationship with Michael was the foundation of that family. Her children are her strength but they cannot fill the void left by her husband's illness—she grieves for the loss of the relationship they once had and she fears for the future.

2. Agnes was diagnosed as having hardening of the arteries in 1980 when she was 64, two years later she was reevaluated and a diagnosis of Alzheimer's disease was made. In 1981 her youngest son moved out of the family home and she was left alone. Her family realized that she needed some supervision if she was to remain in the home but after a year of daily visits it became obvious that she could not continue to live alone.

Her daughter Mary and son-in-law John took her into their home. She still lives with them. At first they were able to use a part-time sitter—someone who stayed with Agnes late in the afternoon when she became extremely agitated (in a condition referred to as "sundowners syndrome"). Agnes now requires constant supervision and Patty was hired as a companion. She is paid $130 a week and cares for Agnes during the hours when Mary and John are working. There is no reimbursement from private insurance or Medicare for such custodial care.

Agnes now weighs 85 lbs (when she was well she weighed about 120 lbs), she eats voraciously, although all her food has to be blended to prevent choking, and because of her constant pacing she wears out a pair of Nike shoes in six weeks. She is sometimes incontinent, especially at night and requires expensive diapering and special waterproof draw sheeting.

Fifteen years ago she was divorced from a federal employee and lost her right to a pension. She worked for a relatively short period of time after the divorce, until she was fired because she was unable to make change in her job as a bakery clerk, and draws a very small Social Security pension. It does not cover the cost of her care at home and faced with the prospect of placing her in a nursing home, probably in the near future, Mary and John constantly worry about how they will afford such expensive care. They are active members of the Alzheimer's Disease Association and work to change a system which seems not to be of help to them when they most need it.

3. Leah is 74, her husband Harry is 77. Harry was diagnosed as having Alzheimer's disease six years ago. Leah has struggled to care for him at home for all these years. She is a small woman (4′ 10″) and she does not have use of her left arm (because of a radical mastectomy 15 years ago and more recent surgery on her collarbone)—her care of Harry has been especially difficult because he is a large man and can be extremely combative.

They have received some help, in the form of Meals on Wheels but there was no day care or respite care to provide a break for Leah from the burden of caring for Harry and she was unable to leave him to attend support group meetings where she might have been able to at least share her burdens with others who understood. Her link with other caregivers was through our quarterly newsletter.

She has finally faced the inevitable and will place Harry in a nursing home, she will be able to pay for his care until their money runs out and then he will become a Medicaid patient. Despite the torment of the last six years Leah loves Harry and she is broken hearted about having to place him in a nursing home—she wishes that she could manage to keep him at home.

4. Marjorie is 59, her husband Doug is 61. He was diagnosed as having Alzheimer's disease in October 1981. He is a retired federal employee and a veteran and has received care through the VA facility in Cincinnati. Doug still manages to eat by himself but he needs help with bathing and shaving. He is no longer able to manage his dental care and even with help from Marjorie he has had problems which require visits to a dentist every two months. He is extremely restless at night, getting in and out of bed and disturbing his wife. He requires constant supervision and although he is still verbal he is no longer able to communicate in any meaningful way.

He and Marjorie enjoyed an active social life and when he traveled (in the course of his work) Marjorie enjoyed friendships and her volunteer work at a local hospital. Alzheimer's disease has changed that, Doug can no longer take part in social activities and he cannot be left alone very long so Marjorie is becoming more and more isolated. She has found her local neighborhood support group of tremendous help and she finds it gratifying when she can help other caregivers.

She is grateful for the Salvation Army day care program which Doug attends three days a week. It gives her time to run errands and catch up on her housework. She is also grateful for a new health policy which will provide some reimbursement for home health care (a most unusual health policy) because she knows that she will soon need some help if she is to keep Doug at home with her.

Doug's mother Anne, who is 83, does provide some respite—she is able to care for him if Marjorie drives him out to her home and she will care for Doug when Marjorie takes a few days vacation with relatives. In addition to the stress of caring for Doug, Marjorie worries about financial matters—she has an annuity which will help to pay for Doug's care but all the careful planning they did together before his illness will not protect her from the enormous cost of nursing home care when that becomes necessary and she knows it is inevitable.

In summary you should know that these are only four case studies chosen at random—they show women coping in the most trying of circumstances—wives, daughters and mothers all caught up in the care of patients who are no longer able to express their appreciation for the gentle, loving care they are receiving. Women have traditionally been the caregivers, the nurterers in the family. As mothers, we find joy in caring for children, for they have the promise of tomorrow—of independence and adulthood but for the caregivers of Alzheimer's patients there is the certain knowledge that tomorrow will bring a further decline towards a second infancy.

We cannot change that but we can provide support for these caregivers—an effective program of day care, with transportation and in-home respite care can lift some of the burden. This will enable families to care for loved ones in their own homes and postpone the often inevitable placement in a long-term care facility. The prospect of such placement and the financial burdens that places on families could be alleviated by an appropriate response from the private insurance companies, the State and Federal government. The Alzheimer's Disease Association of Cincinnati, in partnership with ADRDA-National, supports efforts to provide such coverage through private insurance and State and Federal legislation.

Thank you.

Senator GLENN. Thank you very much. Ann Mootz who was scheduled next is ill and unable to be with us. Joan Nicholas is the associate director, and she will give the testimony today. We appreciate you filling in this morning. Thank you.

Ms. NICHOLAS. Thank you, sir. I am glad to be here too although I am sorry it is because of Ann's illness. I am sure she misses the opportunity. Perhaps I could have your permission to introduce myself as you did the others.

Senator GLENN. Please do.

STATEMENT OF MS. JOAN NICHOLAS, DEPUTY DIRECTOR, UNITED HOME CARE, CINCINNATI, OH

Ms. NICHOLAS. I was the executive director of the Visiting Nurse Association in Cincinnati for 10 years. The Visiting Nurse Association and Home Aid Service, which was the large homemaking organization in Cincinnati merged in January 1984.

Home care is definitely a woman's issue. In our agency we provided nursing, therapy services, health aid or homemaker assistance to 3,181 individuals in September of this year, 77 percent were women. The average was 79 years; 96 percent were financially unable to afford private fee service so had to depend upon government funded programs or United Appeal funds.

Seventy-four percent lived alone without much available support from family or friends. Agency staff have sometimes physically moved clients into better housing or made funeral arrangements simply because no one else was available to help.

As you mentioned a while ago, many home caring individuals were unable to attend today because they were taking care of people at home. We find ourselves involved often in helping individuals appear to give testimony when they can get out of the house by having someone accompany them.

Less home care service is available to these women and our other clients as government restrictions in the past 2 years have limited visits, particularly those of medical social workers, which had been subsidized or paid for by Medicare.

Home care has always been scarce in this country as we have emphasized institutional care. Less than 3 percent of Medicare dollars go into home health care. Even these precious dollars are producing less service as government redtape requires more paperwork with less money left for direct service.

For instance, we estimate that for every hour our nurses spend visiting a patient, they must spend at least another half-hour writing a report of the visit or summaries of those reports to go with bills we send to Medicare.

The picture is even more discouraging when we consider long-term chronic care in the home. Most individuals needing this care are women and the great majority of those providing daily care to disabled family members are women.

With our fast growing older population, we could have anticipated years ago that chronic care in the home, as well as in the nursing home, would reach the current level of seriousness.

It was only recently that the first meeting of national agencies and large insurance companies met to consider the feasibility of long-term care insurance. We have no national program for long-term care in the home and few states have adequate programs.

Ohio has many excellent home care programs and a State commitment to home care, but the supply of services, particularly for chronic care, does not meet the needs, and programs are administered by five different State departments with different requirements and little agreement on standards of care.

The services needed—Meals on Wheels, chore service, telephone reassurance, counseling—are in short supply in many communities. Two key services, respite care to relieve the caregiver and homemaker service to provide direct care—are particularly in short supply.

At United Home Care we probably have one of the larger homemaker programs in the State. We have a waiting list for homemaker service of 393 persons at this moment. Fifty-three percent of these individuals on the waiting list are 70 years or older and 65 percent live alone. Most have been independent all of their lives. They waited until the last minute to call for help, and to be told that they will have a 5-to-6-month wait for help is shattering for them. Three hundred sixteen of the 393 persons on the waiting list are women so, again, home care is a woman's problem.

While there is a growing awareness, thanks to hearings like this, of the special needs of women, particularly those who are elderly, poor, and ill, we don't always consider that many of the women employed in home care are underpaid and lack benefits and secure.

There is a theory in Washington that competition in health care will lower costs and increase efficiency. When home care contracts are awarded to the lowest bidder without any requirements for training of homemaker aides, for benefits, or job security, there cannot be high hopes for good care.

And, in my opinion, these women who work at physically and emotionally difficult jobs without training, without paid sick leave, holidays, vacations and without even a guarantee that they will be employed 40 hours a week are being exploited. This is a serious problem which we fail to address, rationalizing that it is economically necessary. It is an economy that industry, medicine, and Government are pushing, and poor women and minority people are paying the price.

In conclusion, the welfare of women, whether disabled, whether family caregivers or whether employed as caregivers, is deeply affected by our philosophies, our expenditures, and our plans for home care.

We need to develop a national program with standards which protect the patient and the caregiver and to both broaden and simplify State programs so that a larger percentage of those who need care will receive care. Thank you.

[The prepared statement of Ms. Nicholas follows:]

Prepared Statement of Ms. Joan Nicholas

Home Care is definitely a woman's issue. In our agency, United Home Care, we provided nursing, therapy, health aide, or homemaker assistance to 3,181 individuals in September. Seventy-seven percent (77 percent) were women. The average age was 79 years. Ninety-six percent (96 percent) were financially unable to afford private fee service so had to depend upon government funded programs or United Appeal funds. Seventy-four percent (74 percent) lived alone without much available support from family or friends. Agency staff have sometimes physically moved clients into better housing or made funeral arrangements simply because no one else was available to help.

Less home care service is available to these women as government restrictions in the past two years have limited visits—particularly those of medical social workers.

Home care has always been a scarce service in this country as we have emphasized institutional care. Less than three percent (3 percent) of Medicare dollars go into home health care. Even these precious dollars are producing less service as government red tape requires more paper work with less money left for direct service. For instance, we estimate that for every hour our nurses spend visiting a patient, they must spend at least another half hour writing a report of the visit.

The picture is even more discouraging when we consider long term, chronic care in the home. Most individuals needing this care are women and the great majority of those providing daily care to disabled family members are women. With our fast growing older population, we could have anticipated years ago that chronic care in the home, as well as in nursing homes, would reach the current level of serious need. Yet it was only last December that the first meeting of national agencies and large insurance companies met to consider the feasibility of long term care insurance. We have no national program for long term care in the home and few states have adequate programs. Ohio has many excellent home care programs and a state commitment to home care but the supply of services, particularly for chronic care, does not meet the needs and programs are administered by five different state departments with different requirements and little agreement on standards of care.

The services needed—meals on wheels, chore service, telephone reassurance, counseling—are in short supply in many communities. Two key services—respite care to relieve the caregiver and homemaker service to provide direct care—are particularly in short supply.

At United Home Care which probably has one of the largest homemaker programs in the state, we have a waiting list for homemaker service of 393 persons. Fifty-three percent (53 percent) of these individuals are seventy years or older and sixty-five percent (65 percent) live alone. Most have been independent all of their lives and waited as long as they could before calling for help. To be told they will have a five or six months wait for help is shattering to them. Three hundred sixteen (316) of the 393 persons on the waiting list are women so again, home care is a woman's problem.

While there is a growing awareness, thanks to hearings like this one, of the special needs of women—particularly those who are elderly, poor, and ill—we don't always consider that many women employed in home care are underpaid and lack benefits and security. There is a theory in Washington that competition in health care will lower costs and increase efficiency. When home care contracts are awarded to the lowest bidder without any requirements for training of homemaker-aides, benefits, or job security, there cannot be high hopes for good care. And, in my opinion, these women who work at physically and emotionally difficult jobs without training, without paid sick leave, holidays, or vacations and without even a guarantee that they will be employed forty hours per week are being exploited. This is a serious problem which we fail to address—rationalizing that it is economically necessary. It is an economy which industry, medicine, and government are pushing and poor women and minority women, are paying the price.

In conclusion, the welfare of women—whether disabled, whether family caregivers, or whether employed as caregivers—is deeply affected by our philosophies, our expenditures, and our plans for home care. We need to develop a national program with standards which protect the patient and the caregiver and to both broaden and simplify state programs so that a larger percent of those who need care will receive care.

Senator GLENN. Thank you very much. Miss Tatman, you have taken on your responsibilities as a family member beyond what most people do these days. I think that's very true. You have done an admirable job.

I don't want to be too personal in my questions here, but have you considered your own financial security through the years?

Ms. TATMAN. Well, actually, I came on faith. I figured I was doing the right thing, and somehow it would all work out.

Senator GLENN. That's real faith. How about the involvement of your other brother who lives in New Hampshire, does he help out financially or help out with some of the bills?

Ms. TATMAN. He comes several times a year and nails us back together again and keeps us in good shape, and if I should ask for financial aid, he assures me it would be forthcoming.

Senator GLENN. Ms. Trenkamp, regarding the National Alzheimer's Association—you mentioned the four goals they have, including legislative. Is there any legislation that you see that's needed, or is it mainly just doing the research that's necessary to try and get this horrible disease under control.

Ms. TRENKAMP. I think the research is extremely important and obviously the legislation has a bearing on that because it has to be funded at the Federal level. There are several possible resolutions that we have supported and would be very interested in.

One is the Health Research Extension Act of 1985 which provides funding for research. We are also very interested in House Resolution 228 which was introduced by Representative Roybal of California.

Senator GLENN. I don't know it by that number. What does it do specifically?

Ms. TRENKAMP. It provides for national education network to provide information and assistance to families and care providers; a multistate program to encourage and develop coordination of services for Alzheimer's disease and 25 percent of the funds for that would go for respite care; then support for Medicare and Medicaid projects to offer alternative health care delivery systems. Adjustment for nursing home reimbursement and an expansion in the number of Alzheimer's disease centers around the country. There are 10. Five newly funded, one of which is at the University of Kentucky which is close to Cincinnati.

Also, I think just very basically, the emphasis that we have had in the advocacy area is to point out the desperate need for low cost respite, in-home and other support service, the need to broaden long-term care coverage to meet the unique needs of Alzheimer's disease and their families and the need for continuing research. It would be a tragedy to prevent people from dying of heart attacks and strokes and things likes that.

If we condemn everybody to dementia, obviously the ultimate solution is to find an answer through research. I am hopeful that will not be too far away.

I don't know if you are familiar with Dr. Peter Davies' research on acetylcholine, a neuro-transmitter. He is very interested in understanding why acetylcholine is diminished in the Alzheimer's brain and he is very hopeful of breakthroughs. He thinks that within 10 years we will understand this disease and that we will have some treatments available which are not available at this time.

Senator GLENN. I sincerely hope that happens. I want to reread just a couple sentences out of your testimony here because I think they are right to the point.

> Women have traditionally been the caregivers, the nurturers in the family. As a mother we find the promise of tomorrow, with independence and adulthood, but for the caregivers of Alzheimer's patients, there is a certain knowledge that tomorrow will bring a further decline toward a second infancy.

That sort of says it all where Alzheimer's is concerned, I guess.

Miss Nicholas, we appreciate very much you filling in this morning. You commented about contracts not necessarily going to the lowest bidder for a Government contract. I agree with you. I think that quality has to be mentioned or considered and considered perhaps first, not last.

You also mentioned in the last sentence or so of your testimony that we need to develop a national program with standards which protect the patient and the caregiver; to both broaden and simplify State programs so that those needing care will receive it. Do you have any specifics on that or what you would propose for a national program? Do you feel that this should be national or should we leave this to State groups to do something about it?

I don't want to make this a political meeting this morning. I don't want to get into politics too much. But, this administration has cut back in some areas of home care. It has been more difficult for those needing care to obtain it. Home care remedies have been chopped back with suggestions that they be cut back even further. I disagree with that.

Those are not the big budget busting items in Washington. I disagree with it very,.very strongly. Do you think we need a national program or can this be handled at the State level? If so, what would the national program be? I guess that's my question.

Ms. NICHOLAS. I certainly am aware of the cutbacks. We have experienced them and are experiencing them daily each to the extent where clients of ours who had Medicare, elected to have a Medicare HMO and found their home care benefits were cut tremendously. They didn't know they were going to be cut, but they were immediately.

Senator GLENN. Were they aware of this before they ran into a problem?

Ms. NICHOLAS. No.

Senator GLENN. We have had testimony about this in Washington—about people who had Medicare, supplemented it with Medigap insurance and thought they were covered. They thought their coverage was in good shape; and they got wiped out by their health care bills.

Ms. NICHOLAS. This is a situation where we were taking care of them three times a month. When they got the HMO Medicare coverage, they were told that they could have one visit a month only and so when a catheter fell out in the middle of the month, they had to go to the hospital instead of staying home. That kind of thing.

You were asking about the national program. I don't feel that I can say exactly what Ann Mootz meant by that statement. I can give you my own reaction.

I would say more a national policy than a national program, a policy where we could be assured that if homemakers are being used through organizations that are paid for by any kind of public funds, there would be training available. Then there would be trained homemakers, not ones that have no training.

I think that it is important for the safety of those who are cared for at home alone that there be a policy that an agency is accountable for supervision. There has been a lot of abuse. This isn't abuse of the law. This is abuse of patients at home when persons are contracted for directly rather than through an accountable entity. You need someone to be accountable for the supervision of the homemaker home health aide. The Medicare Program handles that quite well. Often, other organizations and funding sources for homemaker services get it done poorly. There are a lot of different funding sources; they are difficult to coordinate, causing increased administrative expenses.

Senator GLENN. Let me ask another question and then I will turn it over to Dr. Binstock. You both referred to respite care. Would you define that and how it works? Mrs. Tatman, would you take that first?

Ms. TATMAN. Respite care is a fine thought and it works. That's the great part of it in that they carefully decide what exactly is needed. They have a previsit in order to ascertain exactly what is needed and then they try to select a caregiver that can fill the bill. In fact, if someone—if your first, say, interview isn't successful, you can go to the second or third until you find someone who really can fill your needs and that's fine.

Senator GLENN. Who actually runs it, Ms. Trenkamp? Is it run by the county? Do Federal funds go into it?

Ms. TRENKAMP. I am not really certain about the funding, Senator. Do you have more Joan.

Ms. NICHOLAS. I would like to attempt an answer. On January 1, United Home Care will have two respite services, one for the developmental disabled where most of the money comes from; one for seniors. They are paid for through a lot of donations and fund raising, but the only third party that I am aware of is through the developmentally disabled organizations.

Senator GLENN. And it provides people that relieve caregivers for a temporary period of time? It is not set up to be permanent?

Ms. NICHOLAS. It is not, no. The respite care is usually provided by what we call stipended volunteers. They get $2.00 or $2.50 an hour which reduces the cost to the recipients, of course. These volunteers are trained. They volunteer to be trained and they will take care of persons for a certain length of time. Sometimes they relieve them on Thursdays or sometimes for a vacation.

Senator GLENN. They would have different skills which is what you meant by they would try to match their skills with what the home care situation requires?

Ms. TATMAN. That's right, because each home would require something different.

Ms. NICHOLAS. And they need to be trained to do the specific things required in that place.

We also—because some things that families do legally, an organization cannot—have a volunteer or an unlicensed person, we have provided R.N.'s for some respite situations: Tracheostomies, colostomies and so on. Those funds are provided by United Home Care's allocation from the Community Chest.

Senator GLENN. Dr. Binstock.

Dr. BINSTOCK. Thank you, Senator. Mrs. Tatman, you certainly illustrate, at least in your case, the meaninglessness of the phrase "the empty nest syndrome." Your nest has never been empty. If there was a national policy that provided money, eligibility, and sufficient social services, just what would your personal feeling be? I think I know your answer from the thrust of your testimony.

Would you have preferred during all these years, and the years ahead, to have used that eligibility to have care provided in the home for your relatives by others and gone back into the labor force yourself, or would you have rather have had an elaborate and appropriate structure of respite care and maintained the caregiving role yourself.

Ms. TATMAN. I would continue to do as I am now as my mother would not be happy with strangers, they would not understand my retarded brother and his special needs, and as long as I can do it, I will.

Dr. BINSTOCK. So that, in effect, from your outlook and your judgment, full funding of respite care would be a top priority?

Ms. TATMAN. Yes, because I do enjoy and need my time off, and I recognize that.

Dr. BINSTOCK. Thank you. Mrs. Trenkamp, do you think the general public understands at this point that Alzheimer's is a disease, one of many dementing diseases, or that it has just become a fashionable term, wastebasket term for senility, because I think this has important implication for adequate health care.

Ms. TRENKAMP. I think there is a tendency whenever you identify something, you want to kind of chuck everybody into the basket, you know. One of the things that we are careful to do when we talk to people is to make sure that they are getting as definitive a diagnosis as they can get.

I think, though, that one thing that you should bear in mind is that no matter what the dementing illness is, the caregiver is left in the same position. In my own family, when my father died, my mother-in-law recently died from a massive stroke which followed several years of deteriorating health.

She suffered from many of the same kinds of problems that my father had and my father-in-law was in the same caring role as my mother. So it really makes very little difference what the precipitating factors are. You are dealing with the same kind of problems.

Dr. BINSTOCK. In a sense, yes, but this brings up a dimension I also wanted to raise with Miss Nicholas, and perhaps you both could respond. You introduced the notion of stroke, of which, of course, there are various kinds. The effectiveness or efficacy of stroke rehabilitation is mixed.

The question I wanted to ask Ms. Nicholas: Does your agency really get involved in rehabilitation efforts at all, or is the outlook entirely in the caregiving mode?

Ms. NICHOLAS. As a matter of fact, our focus is on rehabilitation. If we can rehabilitate anybody, we do. We start with teaching, trying to help persons maintain themselves by teaching them how to do it.

We are currently an intermittent care agency, we visit only a certain number of times or for a certain length of time. The homemaker program does provide ongoing care, but the skilled home health program is definitely rehabilitation and short-term care. We also tend to use an occupational therapist or physical therapist to help the homemakers do some rehabilitation in that area.

Dr. BINSTOCK. Has the Medicare HMO tended to reduce those——

Ms. NICHOLAS. I think so.

Dr. BINSTOCK. So that could be a big policy setback at this point?

Ms. NICHOLAS. I think the potential is there.

Senator GLENN. Your rehabilitation efforts, how successful are they? I know you wouldn't do them if they weren't successful, but with the very elderly, if they are seriously impaired and on a downhill slide, rehabilitation may not help.

Ms. NICHOLAS. I guess it depends on where you start calling them very elderly. We have had good success with rehab efforts. Not everyone gets better. Sometimes rehabilitation manages to maintain what they currently have, bring them back up to the level before they had the acute episode.

Dr. BINSTOCK. From what I can gather, Senator, old age in itself is not the best predictor of good or bad rehabilitation outcomes. The best predictions are the existence or absence of multiple conditions, family environment, the physical environment, and a variety of things, except for Alzheimer's which is at the moment not very susceptible to rehabilitative efforts. But with something like strokes, 80 years of age or 85 would be less of a predictor than several impacting——

Ms. NICHOLAS. We have 100-year-old persons that snap back and can live alone again.

Dr. BINSTOCK. I wonder if I might ask one more question and get the reaction of all three of you. Thank you. I think one of the things each of you have illustrated in your testimony is that long-term caregiving, and where possible rehabilitation, is not necessarily an issue of aging.

Is it really an aging issue? What is the impact of the fact that we address this as a matter of policy through programs focused on the elderly? Other programs focus on the developmentally disabled, which were programs brought about by a coalition of various children's advocates, as I remember for that particular legislation—cerebral palsy, epilepsy, and mentally retarded children.

Do each of you think that this compartmentalization rather than seeing the issue straight out as long-term care hurts our capacities to develop the kinds of respite policies, the kinds of societal attitudes that would be more supportive, and the appropriate kinds of financing, or do you think that going at it in this categorical way of the aged, and developmentally disabled, and a particular disease category and so on make sense?

I would be interested in each of your comments on that.

Ms. TRENKAMP. I think that in my experience there are quite a few people that we have dealt with who have not fitted into particular programs because they weren't old enough for them so I think the establishment of good programs which will meet these things irrespective of age is certainly very important.

Senator GLENN. Wasn't your first example about people in their 40's.

Ms. TRENKAMP. Yes, and they desperately need the kind of respite care and will need the in-home care that they may not qualify for because the gentleman is too strong.

Dr. BINSTOCK. They were either too young or too old.

Ms. TRENKAMP. Yes, yes, definitely. These are human problems. These are not just aging problems although with Alzheimer's disease and related disorders, the incidence is certainly much larger in the middle age population.

Senator GLENN. Mrs. Tatman, do you have any reaction, please?

Ms. TATMAN. I agree with Ms. Trenkamp.

Senator GLENN. Miss Nicholas?

Ms. NICHOLAS. I think it might be politic with a small p to focus on what most interests people at a certain time. As far as providing programs, providing service that people need, I think it is not age related at all. It is simply what is needed at different ages. It is not categorical.

Dr. BINSTOCK. Caregiving has gotten so much attention in the context of population aging and the issues of women coming to the forefront finally. And yet it has been there all along, and over 60 percent of the long-term chronic disabled people in this country are under the age of 65. Yet we speak about long-term care as if it were a synonym for furnishing care to older persons. Over 60 percent of the people with long-term chronic disabling conditions, three-fifths of them, are under the age of 65 in this country.

Ms. NICHOLAS. It is interesting that the client population of our agency is predominantly 65 or older. 75 percent is 65 or older. I think that's strictly a function of funding sources—the category which has been funded.

Dr. BINSTOCK. The hardening of the categories. I heard a speech on stroke the other day where interestingly enough one of the country's leading experts on stroke said something about stroke is basically a disease of old age. And, in fact, it is not. There are about a third as many people between 45 and 65 who have had strokes as there are people 65 and older who have had strokes. In other words, 1 for every 3. Thank you.

Senator GLENN. Thank you all very, very much for your testimony this morning. It has been an extremely informative morning. We didn't take a break between the panels so I know a lot of people are getting sit fever from sitting so long, but we appreciate your patience this morning. It has been very interesting and it brought out some new facts that I am interested in following up on.

As you leave, please remember we have all the publications I mentioned earlier out in the lobby. If you did not pick them up on the way in, we invite your attention to them. Take whatever you like out there.

It would be more useful for you to take them home and show them to your neighbors and friends than it will be if we haul them back to Washington.

We do appreciate you being here this morning and taking an interest in this subject. It is one that we are certainly going to follow up on.

As I mentioned when I started this morning, this is an official meeting of the Senate Special Committee on Aging. This is part of a series of field hearings and it will be entered into the record. Your testimony will be published in the committee record and will be available to other Senators and Members of Congress.

It is not just a matter of having testimony heard here this morning by me and by Tom Luken or Dr. Binstock—who I really thank very much for joining us today. The record of this will go back with us to Washington and it will be useful to the committee and our staff. We appreciate your testimony and we hope, if there are additional questions after the staff has had a chance to review the testimony, that we might follow up with you on some of your suggestions or experiences. If we do, I hope that you would be willing to comment further to us, so it can be included in the committee record.

The Special Committee on Aging will stand in recess subject to the call of the chairman. Thank you very much.

[Hearing concluded at 12:45 p.m.]

APPENDIXES

APPENDIX 1

TESTIMONY OF ANNA V. BROWN

AT A HEARING OF THE U.S. SENATE SPECIAL COMMITTEE ON AGING, "WOMEN IN OUR AGING SOCIETY" OCTOBER 8, 1984, COLUMBUS, OH

Senator GLENN. Anna, we are glad to have you with us. She's director of the Cleveland Department on Aging, has been there since 1971, when the Cleveland Commission on Aging was created. Under her leadership the agency has developed several nationally recognized model programs, including one of the first home care projects.

And earlier this year Anna was elected president of the National Council on the Aging [NCOA], certainly well known in the field of leading organizations. In fact, Anna and I go back a long way. She testified at the very first hearing that I ever conducted outside of Washington, DC, back in 1977 in Cleveland, and I very much appreciated her help and her friendship through the years. I remember that hearing very, very well, because it dealt exactly in some of these areas that Dr. Kaplan says he's not sure are cost efficient when administered at home. And so perhaps you can comment directly on that because her innovative ideas have been in this area of how to serve the elderly in their homes, in the communities, in the blocks without displacing people out of their homes unless that absolutely becomes necessary. So, Anna, we look forward to hearing your statement.

STATEMENT OF ANNA V. BROWN, EXECUTIVE DIRECTOR, DEPARTMENT OF AGING, CITY OF CLEVELAND, OH

Mrs. BROWN. Thank you, Senator Glenn, I'm sure that you are so astute that you don't believe everything that you hear.

I'm indeed glad to be here for this hearing, and I appreciate your invitation from you, sir.

I'm going to read my prepared statement, and then there are some things that I really think I need to say to this audience this afternoon; things that are rather deep in my heart and my feeling about the future of older persons, not only in Ohio, but certainly Ohio being a part of the greater Nation, I have some things that I want to share.

As a society we are likely to extol the variety of our organizational efforts to provide for the aids to improvements to the quality of life for our people. Those service providing agencies represent expertise, and historical commitment which over our history has greatly unified the concept of community responsibility.

The timeliness of this hearing, Senator, is highlighted by a current united way effort. And during the last several years by slogan and volunteer effort, the community responsibility has been heroically supported in spite of a wobbly sick economy.

The separation of private skill/public efforts sometimes lacking coordination, or communication has led to suspension, competition and overkill in our efforts to meet and serve our people. However, the idea of public skill/private partnership is now almost 15 years online here in Ohio. In fact, the concept has been operational since 1971, for in that year we saw the first such alliance in those who came together to plan, implement and expand the capacity to serve the elderly in the model project in Cleveland known as One-hundred By One-hundred.

Here already established agencies with unprecedented commitment to city government leadership came together to develop the comprehensive network of their services to better serve older people. To the credit of the professionals, hard decisions were made. Duplicate services, over response, poor distribution of services were addressed, with community based agencies voluntarily withdrawing services when the mix for a given target group was over worked by the agencies with the same focus or same program. They learned to talk together to plan for the overall meeting of needs.

One-hundred By One-hundred as a model went online and was the prototype of the 680 area agencies on aging which cover the country, at this time. The major needs of older persons were the program focus of the agencies under contract for the delivery of the services.

I would say, Senator Glenn, if you have apprehension about your mother, all you have to do is get in touch with area agencies across this country and we can take care of anybody.

The changes in emphasis in aging are swift. Certainly those changes have been in response to the general economy and the country. The escalation of the old, old population growth, and governmental policies which reflect lately a bottom line money concern while scapegoating the medical and scientific technology which, if examined, says we are over producing too many old people.

Senator GLENN. The alternative to that isn't too good.

Mrs. BROWN. I don't think so either.

The General Accounting Office is to be commended for the study of the "well-being of old people in Cleveland." Out of the GAO study, we found that old people turned to relatives, friends, neighbors before turning to agencies in time of need, stress or emergencies. The GAO study is a landmark in the evolution of programmatic responses to the needs of old people. Bear in mind that the focus continues against institutionalizing which we discussed some 6 or 7 years ago at another hearing called by you, Senator.

What seems to be evolving is a combination of the natural support for old persons. Their families, who have provided 80 percent of the care now given older people, and those agencies which can provide services of more sophisticated disciplines.

Certainly the changes in the life style, education, career choice of women will have a great impact on how we will be able to continue that great family input to the composite effort to provide those caring services to the old.

Women have gone to work. Representing better than 50 percent of the work force. The care givers are not available, and while our concern is the loss of the care givers for the old, there is likewise the care of our young children out of their homes, with too many stories of abuse, sexual and otherwise, being perpetrated on our young.

To meet the challenges of reducing health costs, providing surveillance over an older population, the Department of Aging, City of Cleveland, convened what has become a model for our consideration, another public-private cooperative effort called golden age out-reach for help, incorporated, which has trained older persons in a curriculum developed by the Case Western Reserve Medical staff, Clement Family Care Center, and Chronic Illness Center. The manpower for the program are stipened volunteers, each from their own street of residence. We have used the neighbor, found in the GOA study. Family and friends may not be nearby but the neighbor by definition is there. The experience of the GAO staff show older persons who need help are not so much in need of medical care as they just really need help.

The model is in Fairfax neighborhood in Cleveland where we have 3,000 old black people at poverty and below, but there are 87 percent homeownership. We have a small professional staff, only five. But there are 29 volunteers who are stipened who serve 1,700 enrollees of the program. The thrust of the program being preventive health care, early intervention to short circuit that march to the acute care hospital where the greater health care costs are. What GAO addresses is needs of a basically female population, in need of transportation, shopping trips, assistance with personal care, respite care and shared housing.

GAO acts as the broker for chore services, matching those with skills willing to work for small fees and the elderly who can afford those fees. The GAO model exemplifies the coming combination of public-private, coalition, self help design for service programs for the elderly, emphasizing the use of older persons who are hardy as the provider of services to their own peers who may be frail or impaired.

The preponderance of females in the target population precluded the use of any males in the Street Health Worker Corps, men being rejected entirely in that role, even to serve older men.

And, incidentally, when you say that older men are married, yes, they are; because they have to have someone to take care of them. Your women, the women are independent and know how to take care of themselves basically. But a man can't find his socks for example. They are spoiled. Can't unspoil them.

The new women who are growing older will be better educated, more knowledgeable in the affairs of government, commerce and education. She may have been an executive, perhaps married, but not necessarily, with or without children. The delayed start of becoming a parent in exchange for progress in a career may, over time present new problems.

The relationship of the older parent to a younger child in later years can hold problems leading to frustration and stress. And today we heard Congresswoman Oakar mention that we are not sure of the source of the abuse. I would submit to you that there is a reentry problem when older parents have an old child move back home because of widowhood, divorce, or whatever, there is a reentry problem. And here is the man who can tell you about reentry problems.

Senator GLENN. Only one wife, Anna, so far.

Mrs. BROWN. The housing problems of older women will be best addressed in congregate settings. Shared housing is somewhat questionable. The Chinese—and all respect to the Chinese, and this is no political talk—the Chinese symbol of war being two women in the kitchen.

The fact that 16.6 million elderly women bear the adversities of poverty and neglect in this country should encourage advocates for elderly not to lose hope and paralyze the continuing efforts to improvement of the quality of life for the nations older women. The number of older women has increased with a marked increase in the very old and the frail. More older women are living alone, and while the later generations have better paying jobs and benefits, will fare better in their later years, little progress has been made for 2.6 million who live below the poverty line.

Thirteen million women have no pensions, 1.7 million older women who are unmarried have only social security as a source of income. Some specific statistics which are of interest to us all. Six out of ten Americans over 65, and 7 out of 10 over 85 are women. I won't go into that. You've heard that all day long. These facts have to be paired with late figures of the world. Family members who traditionally have been the care givers. Of the care givers, 53 percent of the women are working.

Decades ago, only 38 percent were employed outside the home. In the Conference Board's recent study, "Working Women," it is noted that 60 percent of all family income is in households where wives are working. With the increase in working opportunities there is an outstanding increase in professionals. What does this mean. Care givers are the heart of the picture. The incidences of crime perpetrated on older women living alone is a very real jeopardy, making for anxiety and stress. Further, for the last survivor what obligations do communities assume in the way of support for the elderly, alone women. What agency provides legal services, who protects the lone older woman's interest in the sale and/or transmittal of real property.

There are populations for whom little in the way of support services have been initiated. The rural areas lacking services pose a bleak old age for many.

And I want you to hear that loud and clear in Ohio because we are basically a rural State.

Problems of foreclosures, real and contrived, have dispossessed many older rural Americans. Family farms are shockingly in decrease in total numbers. Black-owned farm acreage has been lost to developers, speculators and con artists, more often than not. Those dispossessed are old. We have not made a master strategy for rural older Americans yet.

What is more, there is the sorrowful plight of the migratory farmworker whose family is a living sacrifice on behalf of America's breadbasket.

What happens to the older migratory farmworker? Where does old age catch up with them?

In closing, we have some current concerns which we feel the Senate special committee should address. First, we think that protection of women, all women, should be protected under some pension plan if their husbands have worked or they have worked.

Recently we were in Washington for a meeting of the National Health Council. And Senator, this is a very serious, serious problem on the matter of eligibility for organ transplants. It's now an age eligibility argument that we are listening to. We will not give any organ transplants past the age 45. If you are going to live to 90, you are going to have either 45 years of discomfort or 45 years of pleading to somebody to take you to a dialysis center perhaps.

There are also age eligibility for hip replacement. They are saying in the medical profession they don't want to do a hip replacement 'until you're 65 because the hip replacement usually lasts 10 years and by 10 years you might be dead. No one mentioned that if you were 75 and you were going hail and hardy that you may want a second hip replacement to last you until you were 85.

Further, in the matter of the cost of living for older persons, I' am always fascinated by the commodities market and the futures and all of that. We regulate everything or we deregulate everything, but I never heard of anyone ever looking into what happens on the commodities market. And the reason I got interested in the commodities market, I read once in the paper that a man in Sumatra bought up all the black pepper and I went to the market and bought myself two big boxes of black pepper. And the man at the cashiers office said to me, "Why are you buying all that black pepper?

I said, "In 6 months you are going to raise the price, and I won't be able to buy it."

I am also interested in the endentulous condition of our older population; 50 percent of older Americans either have no teeth or those that they have don't fit. And this is hardly conducive to the good nutrition that we are giving to them in those meal sites. And incidentally, with regard to the meal sites, the Commissioner on Aging testified before the hearing on the Older Americans Act, that the contributions, the voluntary—and that's in quotes,—"voluntary contributions were up this year, which proves that older Americans are better off."

I submit to you, sir, that we have had a change of the people who are coming to the meal sites in very great numbers. And I don't know how voluntary it is when somebody says, "Have you put something in the box?" But I do know that people are stretching what they do have left in resources by going for that one meal, and now the very poor older people who would be embarrassed to not be able to put something in the box are now showing up in the soup kitchens in this State, and I think that needs looking at.

I think we ought to look at the death benefit and how that was changed about on Social Security because we have 85 and 90 year old people who are dying and they are leaving 65 year old children who will have to scrape together to give a decent burial. And we've taken away that lump sum except for the spouse, and we have heard all day that spouse is already dead. Those children need to be reimbursed.

And what's more, we have people who are sharing houses with older people that—a woman called my office the other day, and you must realize that in America there are some people for whom the funeral is the finest thing that has ever happened to them. They had the prettiest dress and the most made over them ever in their lives when they are buried. And they want that $1,500 or whatever to put themselves away nicely.

And a woman complained to me in Cleveland, OH, that someone who boarded with her died without any insurance, she could not pull down 245 from any kind of benefit. The city of Cleveland furnishes you a box and a sheet. And she was in tears, almost hysterical, to put her old friend in Potter's field that way. Americans don't like to do that, and I know it. And I want you to do something about that please, Senator.

We talked about all these educating things. And I think education is great, I want us to do these things, we want to get these editors and these TV people and everybody into what we are talking about. But I want us especially out of the Department of Agriculture to do more nutrition education, especially the business of promoting calcium intake. That ought to help the dairy farmers. And ask these people to promote the use of milk, to promote the use of milk and cheeses so that the bone mass of women will be kept intact and osteoporosis and hip fractures will not cost Federal economy $2 billion a year for repair. That's a civic thing and I think we ought to promote it not only for older people but you grandmothers and great-grandmothers begin to tell your teenage granddaughters to do the same thing throughout their lives and they will be better off.

The whole incorporating of nursing homes is a problem that I see getting to be very serious in this country. The bottom line is profit for the stockholders. I hope somebody in Ohio will be brave enough to come up to some of these chain lines that are beginning to infiltrate our borders and say that why don't you be like McDonald's and franchise them locally, and let us have a board of governors so that the quality of care can be guaranteed. I would like to see someone brave enough to do that.

In the matter of what Medicare will or will not pay for, you know, if you lose a limb and you cannot pay for a prosthesis, and incidentally, a prosthesis costs thousands of dollars, then there are special stockings and straps and things that cost $50 a wack, a sock that costs $7, $12, there ought to be some kind of graduation where there would be some help on that so that people would not necessarily be incapacitated.

The matter of how we educate people in the use of taking drugs is an important matter that the Senate special committee can look at. Some of our older people think if they doctor with one doctor it is fine, but two doctors is better, and they will get the same diagnosis and doubling up on the same medicine. Sometimes we are saying they are balmy, when, in fact, they are just over medicated. So therefore we need to do some of those things that can be done to add to the quality of life without spending a lot of money.

Now, we talked about educating. Let's put it all in simple language so that anybody can understand. Let's get our brochures out in plain English and let us not forget the Hispanic, and let us not forget the Polish, and the Italian, and the Hungarian, and all of those in that age group who are not necessarily bilingual. That is a simple thing to do, and we should do it.

Finally, sir, we look at the DRG, the diagnostic related groups, that admit people to hospitals. We are beginning to get stories in the country that people are going home before they should because the margin of profit for our hospitals is whether the patient stays the full length of the Government's allowance. And if they go home earlier than that, the difference is in the pocket of the hospital. I'm submitting to you that we are beginning to hear that people are sent home and are readmitted, and on readmission, they are being examined again with the same set of tests. And you are going to have a double billing on the test, sir. So I can't see that it's going to be very cost saving.

Finally. Finally I ask Dr. Butler, I'm sorry he isn't here, but some years ago we were entertaining some people from the Scandinavian nations prior to the White House Conference on Aging, and they were talking about the fact that aging is growing around the world, the population in the Carribean is doubling in a very few years. Old people are everywhere on this globe. My question to Dr. Butler was, has anyone thought about the military liability of having a lot of people who are elderly, so many of them frail, in the confines of countries who are rattling swords, who are not willing to sit down and talk and negotiate. I assure you, sir, no older person in America wants to walk down the streets of Columbus with their flesh in threads hanging from their bones, and neither do I plan to meet you on Public Square in Cleveland with my eye balls in my hand. [Applause.]

Senator GLENN. Thank you Anna, very, very much, I think.

You've given us a good list to look at. Quite seriously I'm not making light of your last point—what happens if we ever get into some kind of exchanges like that is almost too horrible to contemplate. I have a military background of some 23 years, went through a couple of wars, and I've seen people die, and I don't want to see any more die. That is one reason why when I first got to the Senate, I started working on that problem even though it was sort of abstract and it resulted in the Nuclear Nonproliferation Act of 1978, of which I am principal author.

And I'm sorry the last two administrations—I get very excited about this, this one and the previous being bipartisan—have not lived up to our wants in that Nuclear Nonproliferation Act. I think that is a tragedy. I share your views on that. I still work on that almost every day. In the office we are looking into some of those problems, why we can't get on with arms control negotiations, and I'm not saying just that this administration, it applies to the last administration, also. So I think we should be pushing for it, and I want it to be verifiable. We can do those things if we just get on with it, it can make a lot of us dead before we ever get old, so maybe it does fit in an aging hearing after all.

But Anna, you and I have both mentioned the hearing back in Cleveland in 1977, and you mentioned the GAO report, the General Accounting Office report. The care being given to the elderly in Cleveland, their study centered in Cleveland and those living in their homes and communities. The purpose of that hearing was to follow up on the GAO study, and it discussed some 23 Federal programs. It pointed out, as I recall, 134 different programs through which assistance was being provided, and Cleveland had been doing quite a lot to help the elderly.

You played a very major leadership role in those innovative programs. Was there any one thing that you did, or how you set out to get community participation, because if we want to set up an ideal way of taking care of the aging, it would be OK for families to take care of families. Well, that doesn't happen. About 75 or 80 percent of the help for the elderly does come from families, but that leaves 20 percent of the people who are in deep, deep trouble. They need help. Well then you say we'd like to have local help.

Well, sometimes that works and sometimes that doesn't. Then we'd like to have State help or Federal help or a combination of all of these things. Now, you've been successful putting together community programs in Cleveland. Can you give us any advice that you can pass along to other communities as to how you do this, or how do you get community participation?

Mrs. BROWN. For one thing, I think necessity, I had no money, and you had to put it together if you were going to get it off the ground. First, we only had a very small grant to start. But I looked around to everything that was already operating and I began to make friends and linkages and bridges, and I do business with anybody who wants to do something for old folks. If it is a bottling company, fine, what have you got, yes, take it, anything.

I also do business with the utilities. We have a great program in the survival of older people called keep the lid on. We parley a lot of our programs on other people's bad images and then they get a rate increase down here in Columbus at the PUCO, and I have an idea that old people are going to be cold and I've been researching hypothermia for 5 years and find out that 25 to 40 percent of your body's own heat goes out through the top of your head.

You can believe that I'm going to call east Ohio and say, "I know how to make you look good and smell like a rose. Come over here and let me tell you what I want you to do for old people in Cleveland by way of educating," and we've given out for 2 years now over 1,000 knitted hats for old people to wear.

We had Cleveland Electric Illuminating Co. come up and do a new pin with a logo with a little man saying, "Keep the lid on." We made Blue Cross-Blue Shield give us a survival brochure, 140,000 of them in all the major languages. We gave the pins out through the school system, 40,000 children went home with that on. But the important thing is 10 American cities this winter are going to do that program under the auspices of the American Gas Association. Now, that is what I'm talking about.

Now, to get them together, Senator, I have turf problems. Some of my people sitting right here if they have turf problems, I have two tables in my conference room. If they are hostile, don't speak to each other, can't stand the sight of each other, I use the small table. Then the elbows have to rub, have to look right into each other's eyes. And I let them know that neutral ground is right where I'm sitting. And if they have turf problems they'd better go now, and nobody ever goes, and therefore we get the job done.

But we make a mixture of public-private schools, churches. Somebody's giving me 1,000 blankets for old people on the kick-off day for keep the lid on. It's easily done, if we make the linkages. If we know what the resources are. If we tell somebody with enthusiasm what it is we want to do, and we can get it done. The GOH project is five agencies all well established, they formed themselves into a nonprofit.

Well, we didn't want to make any one Cleveland agency pay for it, so we made also a consortium of funding sources. Remember that model project that uses a street health worker on each street in their neighborhood to give surveillance to that population, all the money for that was raised in the city of Cleveland. There isn't one dime of Federal money. We have a small grant from the State of Ohio and a little community block grant money, but we did not write to AoA for any money.

Senator GLENN. I have another suggestion for a program like this is to have a Brown in every community. [Applause.]

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

Women are reared to be caregivers and thus provide the care. A creative approach could be to include men in the caregiver group via education for the need for them to caregive also. Support groups would be a good addition to current services. Insurance for these and other supplemental services (respite, etc) in the homes and institutions would seem a good alternative financing pattern of government monies. While I think families (especially women) are stressed to a great extent, I think priority needs to go to people without families to provide the necessary care whether they are in homes or institutions. I think institutional care should be the last resort. I also envision parent care along with day care for children for working adult children as a way to help employees keep their relatives in the community. I think people should work to contribute to our economic base and have parent care deductions available for families.

Margot Marples
Cincinnati, Ohio

The vast majority of elderly wish to live independently, but are finding it increasingly difficult to do so, with increased costs of housing, especially rentals.

Subsidized housing, with support services available, should be increased. Other housing options should be encouraged.

Senior adults are indeed very stressed in trying to figure out and fill out the confusing medical insurance forms and medicare forms. Long term insurance should be explored as part of Medicare.

Rosalyn Shirkler
Cincinnati, Ohio

Working with patients with arthritis has given me a new concern for the aging population we are becoming. I have cared for the terminally ill before this and find the needs and equipment needed to be self sufficient as a person with arthritis is equally important as my previous work. We need good transportation, close access to buildings, good communications as to the exact location of offices for those who find walking very difficult because of pain. We need to understand hands no longer work or arms no longer lift the weight necessary to do work with these people. They do not want handouts and would love to work part time or in easier positions in a company. Because of our ideals of the most efficient product -- we are dismissing many good people.

Mary F. Nordlund, R.N.
Cincinnati, Ohio

Securing autopsies has become an economic issue. Families who have spent life savings caring for members suffering from Alzheimer's Disease are now being expected to pay for an autopsy to confirm the disease. As research proceeds to develop diagnostic procedures that may confirm the disease prior to death, a system to establish payment for autopsy must be developed for families now. Because Alzheimer's produces more questions than answers, families should not be left after the loss of their loved one with the lingering question, "Was it really Alzheimer's Disease?"

Marcia A. Chavarra
Chilicothe, Ohio

I agree that medical and living expenses of elderly family members should be allowable as a tax deduction for the child or other caregiver. It certainly is a legitimate expense regardless of the family's income.

Imogene C. Rettos
Gahanna, Ohio

As a 67 year old listener this morning, I can say only that aging should be approached as a progression in one's life experience -- not as something to be feared or avoided or resented. I think that is one of the problems in our youth oriented culture. I do not apologize for growing older!

Margaret Hendy
Cincinnati, Ohio

Thank you for this opportunity to become aware of thoughts regarding the topic at hand. I am especially interested in seeing more tax exemptions for those who do take care of their own elderly parents.

I believe tax benefits have become increasingly unjust for the mother who choses to remain at home. It seems that inflation and increased taxes causes undue stress for young families. Young families are less and less able to save and prepare for their own future independence and self support.

Anne Willmann
Cincinnati, Ohio

Home health care that is reliable and available at reasonable cost is needed. My mother is 95, blind, is at home with me and getting about using a walker. She is in a familiar environment and I pay (from her monies) for nursing care - a nurse aide, so that I can leave the apartment. This is fairly expensive ($400 monthly) for skilled and reliable care. Should the care become more than I can manage, skilled nursing home care will be very costly.

Ruth Longley
Cincinnati, Ohio

Do you know that we cannot find housing with more than one bedroom? If you use a wheelchair and sometimes need an aide, one bedroom just isn't enough.

Marienne Fields
Cincinnati, Ohio

The problem of the high cost of long term nursing home care needs to be addressed. The average family's life savings can easily be exhausted by the need for nursing home care.

Sally Eversole
Cincinnati, Ohio

As a community health nurse, Cincinnati Health Department, I am concerned about the inadequacy of home health services which can be made available and the lack of funding for home health services. Clients are being discharged from hospitals early without opportunities to recuperate. Frequently people require "maintenance" service which is not funded under Medicare, i.e. homemaking, etc. The kinds of services necessary are not available in adequate supply. Fragmented and inadequate medical programs are not meeting the needs of the population, and I would hope that a national health program could be devised to achieve a healthful standard of living for the entire population regardless of age, sex, etc.

Elaine Varland
Cincinnati, Ohio

Included in legislation that would provide funding or reimbursement, tax credits, etc. to families who care for parents or a spouse at home instead of a nursing home: Principal family members should be required to participate in a preparatory education program as well as a support or continuing education group. Such education is available from a variety of sources in the community at little or no charge. Formal home caregivers should be educated and trained and so should informal caregivers. Families ability to cope should be addressed.

When a Medicare recipient is hospitalized, an assessment of all possible at risk iatrogenic problems should be implemented. Iatrogenic problems often extend length of stay and/or ultimate outcome of placement. Rehabilitation should be a major focus of all service provided: the goal being to restore functioning in all areas, i.e. physical, emotional, social, etc. -- family functioning as well.

Elizabeth Jayne Gothelf
Cincinnati, Ohio

A great need is increased legislation for reimbursement for Adult Day Care Centers. In the areas of respite for families caring for Alzheimers victims is essential.

Coverage for home health services - particularly in the area of more dollars for the home health aide to assist individuals in the activities of daily living, i.e. bathing, laundry, meal preparation etc. All the emphasis is on skilled care and the real need to keep the older adult in the home is with care on a homemaker level with supervision by the registered nurse.

Margaret F. Walker, R.N.
Cincinnati, Ohio

The emotional issues need addressing since they often become illness issues. As an example, an 81-year old client who saw her doctor eight times in an 8-month period was "worried sick" about IRS hounding her. When this matter was cleared up, she "miraculously" felt much better and ceased her visits to her M.D.

Hospitals are so expensive because they're taking on the business better handled by the community agencies, i.e. doctors are sending people to hospitals to admit to nursing homes. The cost of three days in a hospital is unnecessary. A community social worker could accomplish the same things less expensively and more humanely.

Ellen Bloomfield, ACSW
Cincinnati, Ohio

The federal government should designate funding for long-term health care alternative programs at the federal and local government level, and particularly the private market arena. Funding should be earmarked for demonstration projects particularly directed to private sector alternatives -- both profit and non-profit.

William Combs
Cincinnati, Ohio

We need complexes of continuing care -- independent living, assisted living (some survelliance, medication regulation -- of administration to be sure of correct dosage and timing -- hygiene of body and clothing) -- and holistic long term care; this then gives security which is so necessary to the elderly if they can move from one level to the next.

We need to make possible long term care in hospitals for extension of DRG program. Insurance must be planned for all this without all the variety of plans. Medicare covers so little!

Sister Agnes
Cincinnati, Ohio

Appendix 3

Patricia Shelton
1622 Quebec Rd.
Cincinnati, Oh 45205

November 5, 1985

Senator John Glenn
United States Senate
Special Committee on Aging
Washington, DC 20510

Dear Senator Glenn:

I support the upcoming hearing in Cincinnati, on November 18, 1985, "Challenges for Women: Taking Charge, Taking Care."

As a care giver for my mother who is an Alzheimer's Disease victim, I can identify with the many problems that must be faced and solved. Due to the fact that I am a full time secretary in addition to being a full time caregiver, it may not be possible for me to attend. Leave is used up rapidly covering sitter cancellations, doctor appointments, illness and hospitalization, etc.

Mother was 64 when she reached the stage where she could no longer perform her job as a bakery clerk. That was 5 years ago. About 3 years ago she could no longer take her prepared lunch from the refrigerator, it was time to find a part time sitter or companion. Other family members were pressed into service calling agencies, senior groups, looking for the assistance she needed to remain independent. We were able to get mother a part time homemaker for a few short months on a program that trained homemakers through Catholic Social Service and Hamilton County Welfare. This program was for rehabilitation, and after taking mother for a second medical opinion, were told they would discontinue coming to her 4 hours a day. She could not be rehabilitated. At this time mother moved in to live with my husband and myself.

This was an option mother never wanted...but how does one plan ahead to cover loosing one's mind. It was a hard adjustment period for all of the family.

We joined the local Alzheimer's Disease Association and through family support groups manage to "hang in there." At this time the local chapter is an education service--advising self help through sharing experiences. It helps not to learn everything the hard way, but it doesn't help the physical demands of the "36 Hour Day" of a caregiver.

Today, my mother is still at home with us, we take it a week at a time now. She is totally dependent--from dressing her before we leave for work 'til we tuck her in at night. Mother is content and peaceful, handling her small stuffed friends and taking her sitter to the refrigerator for one of her 4 meals or many snacks that sustain her constant pacing. (Mother weighs only 83 lbs.) She can still give you a grin and rub your hand and say "nice." It makes the short night and the long day tolerable.

Placement in a nursing home would relieve our physical burden---but increase the sense of loss that now overwhelms her. People spend all their lives collecting, buying possessions, then they become frail, no longer the vital,active contributors to society, and they must forefit all their belongings to live in a dormitory arrangement. Mother may not remember how to use her treasures, but she knows their hers.

There is no way her social security pension of $267 per month and and alimony alotment of $100 from her ailing exhusband, can cover her expenses at home, much less a care facility.

At home I have an untrained sitter companion 40 hrs. per week. Lunches must be provided for both of them. Laundry never ends, neither does cleaning up spills and carpet cleaning. Incontinent diapers cost $60 a case. Nike running shoes which wear out about every 6 weeks begin to get expensive. She has all the needs of healthy people, hair cuts, clothing, etc. Mother doesn't qualify for welfare until she spends down $130 per month. Sitter fees are custodial and not included for spend down. All household expenses are covered by my husband and myself.

Nursing homes run from $2,000 per month in this area and they never seem to have a vacancy for an aid patient where you apply. My mother was a bakery clerk who worked for minimum wage, she never accumulated the savings to equal these living expenses.

Alzheimer's Disease isn't classfied as an illness by Medicare and they do not pay for custodial care. Due to the $1,200 alimony, IRS declares she can't be a dependent.

Respite for Seniors is a very limited program. They need a 1 week advance notice and their service is not in order for the caregiver to go to employment. Private agencies are beginning to fill this need. A service is offered locally, with an advance interview and 24hrs. notice, you can get a home aid for $7.00 per hour(min6 hrs). This is expensive for people on fixed incomes.

I support any program that will relieve the burden of the caregiver and improve the care of the loved one, but not another bureaucracy. The most frustrating experience for a caregiver is having a social worker sympathize that "you have your hands full," what caregivers need are helping hands.

Middle class people must bear the full burden of care or completely "dump" their loved one in a home to avoid financial collapse. I am not unique. There are many people caring for their loved ones at home. These are creative not to mention thrifty people. They struggle to meet the needs and demands of the ill and disabled because they care, they surely aren't paid in cash.

Science has extended life, now it is time to improve the quality of life for the infirm, the elderly. People have had problems like mother back through history, only other factors brought death before the condition was so totally consuming. Others were parked away in nursing homes away from the public eye.

I was born near the end of the baby boom, hopefully I'll see some reform or work long enough to amass the fortune my last years will cost.

Respectfully yours,

Patricia Shelton

cc

University of Cincinnati
Medical Center

College of Medicine

Department of Internal Medicine
Division of Immunology

Mail Location 563
231 Bethesda Avenue (Rm. 7562)
Cincinnati, Ohio 45267-0563
Phone (513) 872-4701

November 18, 1985

Senator John Glenn
Senate Special Committee on Aging
Washington, D.C. 20510

Dear Senator Glenn:

I am pleased to have the opportunity to attend the hearings today on "Challenges for Women: Taking Charge, Taking Care," and to offer the following statement in testimony on this important topic.

As a physician and internist responsible for an academic research, teaching and patient care program for patients with rheumatic, allergic and immunologic diseases, I have realized within the past decade that there are an increasing number of patients with these disorders who acquire them during the latter half of life. We also know that many of these diseases are now better treated so that both the morbidity and mortality have been reduced. There are, therefore, more patients living longer who have many chronic illnesses. It is also our observation that many older people have not one, but many of these controlled but chronic disorders and yet still acquire acute diseases as well. Particularly with the rheumatic and immunologic disorders, a large percentage of these elderly patients are women. With the ever increasing number of older patients and the fact that more women than men live longer lives, it is essential to have a health care system which allows early detection of disease, so that the morbidity and mortality can continue to decrease. It is also essential to have a health care system which will provide the support systems to reduce disability and allow older patients to live more productive lives.

Finally, and perhaps most important of all, support of research in these disease areas so that we can hopefully prevent and cure these common illness of elderly women,should be an essential component of the United States health care system. I and my colleagues concerned with these disorders, wish you well in your endeavors and will support your efforts in any way that we can.

Sincerely yours,

Evelyn V. Hess, M.D., F.A.C.P.
McDonald Professor of Medicine
Director, Division of Immunology

Patient Care • Education • Research • Community Service